BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Amended Accusation Against: Jeffrey A. Cullen, M.D. Physician's & Surgeon's Certificate No. C 54416 Respondent.	Case No.: 800-2018-049427

DENIAL BY OPERATION OF LAW
PETITION FOR RECONSIDERATION

No action having been taken on the petition for reconsideration, filed by Gabriel M. Benrubi, Esq., on behalf of respondent, Jeffrey A. Cullen, M.D., and the time for action having expired at 5:00 p.m. on March 6, 2023, the petition is deemed denied by operation of law.

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Amended Accusation Against: Jeffrey A. Cullen, M.D. Physician's & Surgeon's Certificate No. C 54416 Respondent.	Case No. 800-2018-049427 ORDER GRANTING STAY (Government Code Section 11521)

Gabriel M. Benrubi, Esq. on behalf of Respondent, Jeffrey A. Cullen, M.D., has filed a Request for Stay of execution of the Decision in this matter with an effective date of February 23, 2023, at 5:00 p.m.

Execution is stayed until March 6, 2023, at 5:00 p.m.

This Stay is granted solely for the purpose of allowing the Board time to review and consider the Petition for Reconsideration.

DATED: February 23, 2023

Reji Varghese
Interim Executive Director
Medical Board of California

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Amended Accusation Against: Jeffrey A. Cullen, M.D. Physician's and Surgeon's Certificate No. C 54416 Respondent.	Case No.: 800-2018-049427

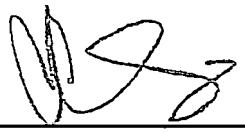
DECISION

The attached Proposed Decision is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on February 23, 2023.

IT IS SO ORDERED: January 24, 2023.

MEDICAL BOARD OF CALIFORNIA



Laurie Rose Lubiano, J.D., Chair
Panel A

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Amended Accusation Against:

JEFFREY A. CULLEN, M.D., Respondent

Physician's and Surgeon's Certificate No. C 54416

Case No. 800-2018-049427

OAH No. 2021120060

PROPOSED DECISION

Abraham M. Levy, Administrative Law Judge, Office of Administrative Hearings, State of California, heard this matter on September 26 through 29, 2022, by telephone/video conference.

Christine Rhee, Deputy Attorney General, Department of Justice, represented complainant, William F. Prasifka, Executive Director of the Medical Board of California, Department of Consumer Affairs, State of California (board).

Gabriel M. Benrubi, Attorney at Law, Davis, Grass, Goldstein & Finlay represented respondent, Jeffrey Cullen, M.D., who was present.

The matter was submitted on September 29, 2022.

SUMMARY

Complainant asserts that respondent's license should be subject to discipline because he committed gross negligence with respect to one patient and repeated negligent acts in his care and treatment of four pain management patients.

Complainant proved by clear and convincing evidence that respondent committed repeated negligent acts in his care and treatment of all four patients. Complainant did not prove by clear and convincing evidence that respondent committed gross negligence.

Based on the evidence of record as whole, consistent with the board's disciplinary guidelines, it is concluded that respondent's license should be placed on probation for three years with terms and conditions to ensure public protection. Reasonable costs are awarded.

PROTECTIVE ORDER

A protective order has been issued on complainant's motion sealing Exhibits 11a, 11b, 15a, 15b, 15c, 15d, 15d, 15e, 15g, 19a, 19b, 19c, 19d, and 19e. The confidential names list has also been placed under seal. A reviewing court, parties to this matter, and a government agency decision maker or designee under Government Code section 11517 may review materials subject to the protective order provided that this material is protected from disclosure to the public.

FACTUAL FINDINGS

Jurisdiction

1. Complainant filed the first amended accusation on February 15, 2022. Respondent had previously timely filed a Notice of Defense to the initial accusation.

2. Complainant alleges two causes to impose discipline on respondent's license in the first amended accusation: respondent committed gross negligence regarding his treatment of patient A (First Cause for Discipline), and respondent committed repeated negligent acts in his care and treatment of patients A, B, C, and D.

License History

3. On November 5, 2010, the board issued Physician's and Surgeon's Certificate Number C 54416 to respondent. The certificate is current and will expire on November 30, 2022, unless renewed. Respondent has no history of discipline.

Prehearing Motion

4. Respondent filed a motion in limine to limit the testimony of complainant's expert witness, James Huang, M.D. Respondent's motion was denied and a ruling and order issued.

Summary of Respondent's Treatment of Patients, Prescriptions for Controlled Substances, and Testimony of the Parties' Experts

5. Respondent's care and treatment of Patients A, B, C, and D are documented in the patients' medical records, respondent's progress notes for these patients, respondent's summaries, and other information of record. Complainant called

James Huang, M.D. to testify as an expert; respondent called Loretta Sutphin Stenzel, M.D., and Nicolas Badre, M.D. Dr. Badre, a forensic psychiatrist, testified regarding prescriptions of benzodiazepines and Ambien to Patient B and benzodiazepines to Patient C. In summary, these materials and the testimony of these experts show the following:

PATIENT A

6. On April 5, 2017, Patient A, a then 51-year-old man, saw respondent at San Diego Family Care (SDFC) for an initial visit. SDFC is a federally qualified health center (FQHC) that serves largely underserved community populations, including a notable portion of the population with substance abuse problems and who are taking addictive controlled medications.

7. Respondent saw Patient A for a short time period, from April 5, 2017, until November 13, 2017. Before he saw respondent, he received treatment at the clinic. On November 13, 2017, respondent terminated Patient A as a patient, after a pharmacy reported he seemed to be under the influence of alcohol, and he told a pharmacy staff person he sold controlled substances prescribed to him to pay for his medications.

8. On April 5, 2017, the record indicates that Patient A returned to the clinic for follow-up for chronic neck and back pain. He had neck surgery in 2013. Respondent confirmed he had this surgery based on the exam he performed of Patient A that showed a scar on his neck consistent with surgery. He was reported to have chronic pain since his surgery in 2013.

9. Patient A was requesting refills for the controlled substances he was taking which included methadone, methylphenidate, and oxycodone. Methadone is an

opiate and a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (c). Oxycodone is an opioid and a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b). Methylphenidate (brand name Ritalin) is a stimulant and a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (d). It is commonly used to treat attention deficit/hyperactivity disorder (ADHD).

10. Respondent assessed Patient A at this first appointment with cervicalgia and back pain. Respondent's plan was to obtain and review Patient A's prior medical records and refill his prescriptions. In a subsequent note respondent recorded that Patient A was gathering his medical records for a pain management consult. Respondent made a direct "urgent" referral for Patient A to an orthopedic surgeon due to decreased strength and mobility in his hand. This referral was made on June 16, 2017. However, Patient A did not appear at his scheduled appointment on September 26, 2017, for this referral as documented in a note from the orthopedic provider dated September 29, 2017.

On October 12, 2017, five months after he began seeing Patient A, respondent referred him to pain management specialist John Qian, M.D.

11. When respondent first saw Patient A, Patient A had been receiving high doses of oxycodone and methadone, in addition to Ritalin, purportedly to treat ADHD, for an extended, though unclear, time period. Per a Controlled Substance Utilization Review and Evaluation System (CURES)[1] report for the period January 1, 2016, through

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[1] CURES is a database of Schedule II, III, an IV controlled substances dispensed to patients.

January 1, 2019, another physician prescribed Patient A 270 pills of 10 mg methadone, 180 pills of 30 mg oxycodone and 120 pills of 10 mg Ritalin.

12. Respondent, more or less, maintained Patient A on the quantities of these narcotics and Ritalin, from April 2017 to September 13, 2017. As mentioned above, respondent discharged Patient A as a patient on November 13, 2017.

13. At the initial April 5, 2017, visit, respondent assessed Patient A for possible alcohol abuse through an Alcohol Misuse/Abuse Audit (Audit C). The Audit is scored on a 1-to-12-point scale; a score of "4" for men is considered positive. Patient A stated he drank alcohol four times a week and had one to two drinks at a time. Patient A was scored at "4" on the 12 point scale.

14. Patient A's use of alcohol, and possible abuse of alcohol, became an issue on July 10, 2017. On this date, Patient A, while drinking alcohol at a bar, went outside and fell and hit his head. He was knocked unconscious for two to five minutes and taken to the emergency room (ER) at Sharp Memorial Hospital (Sharp). Patient A stated at the hospital he was drinking at the bar, went outside to smoke, and tripped. He said he did not remember the incident. Bystanders told him he was unconscious for one to five minutes.

15. At Sharp, Patient A's history of present illness was identified as hypertension, alcohol abuse, and multiple surgeries for traumatic injuries. He was described as not "particularly intoxicated," and a blood test was not done. A CT scan showed no intracranial injury. The diagnostic impression was acute mechanical fall, acute blunt head trauma, concussion, and an 8 cm laceration.

16. SDFC obtained the hospital records of the incident from Sharp on July 16, 2017, and they were made part of Patient A's chart.

17. On July 10, 2017, Patient A called respondent's office to see if he could pick up his prescriptions early.

18. On July 14, 2017, Patient A saw respondent for follow-up regarding the fall and the July 10, 2017, ER visit. Patient A did not, it seems, tell respondent he fell outside a bar while drinking, per the note. He told respondent he tripped on the sidewalk. He said he had thirteen stiches placed. Respondent requested the emergency room records, which he obtained, as noted, on July 16, 2017.

19. Despite receiving the records, respondent did not record in his subsequent visit with Patient A on August 14, 2017, that he discussed with Patient A his use of alcohol or the incident.

20. Despite prescribing Patient A high dose opioids and Ritalin, respondent did not have Patient A sign a Controlled Medication Agreement until August 14, 2017, after he fell outside the bar. According to the terms of this agreement, Patient A agreed to not abuse alcohol (Item 20) while taking controlled medication; he agreed to urine drug testing (Item 2), and to submit to an Opioid Risk Tool (ORT) at least once a year. He was further advised that CURES reports may be run to confirm he was receiving his medications from one provider. An ORT assessment was not done for Patient A. If it was shown he was getting controlled substances from more than one provider, the SDFC provider may decline to prescribe any controlled substances.

21. Patient A was advised by this agreement that SDFC "does not offer chronic opioid treatment." If Patient A wanted this treatment, he would be referred to an outside pain management physician or addiction physician. "If the Pain Management or Psychiatry/Addiction medicine physician determines that opioids or

benzodiazepines are NOT clinically indicated, then the Primary Care Provider will clinically appropriately taper the patient down and off of these controlled substances."

Patient A specifically agreed to be referred to Pain Management or Behavioral Health/Psychiatry if the PCP found this appropriate.

22. According to Patient A's CURES report, on April 5, 2017, Patient A filled prescriptions written by respondent for the following: 270 tablets of 10 mg methadone; 120 tablets of 10 mg methylphenidate; and 120 tablets of 30 mg oxycodone.

23. From May 2, 2017, through June 16, 2017, Patient A returned to the clinic and saw respondent approximately three times.

24. Respondent first noted Patient A's ADHD diagnosis when he recorded in the June 2, 2017, note that Patient A's ADHD symptoms were controlled by therapy. This information appears to have come from Patient A; the therapist was not identified.

25. It is not clear from his note how respondent came to the ADHD diagnosis he initially made on April 5, 2017. He never assessed Patient A for ADHD, and he never obtained medical or other records to corroborate this diagnosis.

26. On November 8, 2017, a staff person at the pharmacy where Patient A was obtaining his medications contacted respondent's office to advise respondent that Patient A seemed to be intoxicated from alcohol, he smelled of alcohol, and Patient A admitted to one of the pharmacists that he was diverting narcotics he obtained so that he could pay for his medications. Respondent voided Patient A's prescriptions for

narcotics that day. In a letter dated November 13, 2017, respondent discharged Patient A as a patient.

27. On November 8, 2017, at his last visit with Patient A, Patient A reported that he was dizzy. Respondent had Patient A undergo an electrocardiogram (EKG). which was normal.

TESTIMONY OF COMPLAINANT'S EXPERT, DR. HUANG, REGARDING RESPONDENT'S TREATMENT OF PATIENT A

28. Complainant called Dr. Huang as an expert to testify regarding respondent's treatment of Patient A and the other patients in this matter. Dr. Huang is board certified in internal medicine and has been an attending staff physician and hospitalist providing primary care at Loma Linda Veteran's Administration (VA) Medical Center since 2000. Dr. Huang is also an assistant professor of medicine at Loma Linda School of Medicine, where he has served since 2002, and served as clinical assistant professor of internal medicine at University of California at Riverside until 2019. In this capacity of a professor, he supervises residents and interns in outpatient and inpatient settings, and instructs them on the standards of care to follow. He earned his medical degree from the Boston University School of Medicine. He completed his internship and residency in internal medicine at the University of California at Los Angeles/VA West Los Angeles Medical Center in 1993, and he completed a fellowship in gastroenterology at the University of Southern California/Los Angeles County Medical Center in 1994.

29. At Loma Linda VA Medical Center he has served on the Patient Safety Committee and Pharmacy & Therapeutics Committee since 2019. Dr. Huang spends about 50 percent of his time teaching and 50 percent of his time seeing patients. Dr.

Huang has regularly prescribed opioids to treat chronic pain. He has kept up on the literature regarding treating chronic pain. Dr. Huang has served as a medical expert reviewer for the board since 2004 and has reviewed 30 to 40 cases in that capacity. Dr. Huang has also published articles in the Open Journal of Clinical Medical Case Report in 2016 and 2017. Dr. Huang sees about 40 to 60 patients per week and has treated numerous patients for chronic pain management.

30. Dr. Huang is familiar with the applicable standards of care. In assessing whether respondent departed from any standards of care he reviewed the evidence of record regarding Patient A and he prepared a report summarizing his conclusions. In response to a question by respondent, Dr. Huang testified the standard of care should be the same to ensure equal care for all patients regardless of what community the physician practices in.

With respect to Patient A, he identified three issues where he found departures from standards of care: Evaluation and non-opiate management of chronic pain; monitoring of opiate pain therapy; and methadone usage. His testimony is summarized as follows:

31. Regarding the standard of care for the monitoring of chronic opiate therapy, he stated that if the use of opiate medications outweighs the risks, and if non-pharmacologic and non-opiate pain therapy did not adequately control the pain, then opiates with the lowest potency and addiction potential should be tried first. The patient should be monitored while under opiate therapy to assess the benefit and harm, levels of pain, functioning, and any adverse effects. To continue opiate pain therapy, there should be achievement of functional goals. If both the patient and physician agree to continue opiate pain therapy beyond 90 days, titration of pain medication dosage should be slow. Ideally, the Morphine Equivalent Daily Dose

(MEDD) should not exceed 80 to 90 mg per day. The risk of accidental drug overdose and death and adverse effects increase significantly beyond this dosage.

32. The patient's risk of drug addiction and aberrancy should be assessed prior to starting long term opiate therapy. Risk stratification is one of the most important tools a physician has to mitigate against potentially adverse consequences of opiate therapy. This easily can be done using the ORT questionnaire and other questionnaires. Patients with above average risk of addiction can benefit from a referral to psychiatrists who are adept in addiction treatment. Patients can also benefit from closer monitoring including the use of urine drug testing (UDT) and consultation of CURES reports. Patients should be monitored every one to three months to assess whether the treatment is meeting a patient's goals of improved pain and functional status. This monitoring allows the physician to discontinue or taper the opiate medications if they are not meeting the patient's goals. The regular assessments and monitoring in clinical visits should be used to assess adverse effects, aberrant behaviors, analgesia, activities of daily living, and the patient's affect. Strategies of monitoring include use of CURES, UDT, and pill counting. If drug abuse or diversion are suspected, a face-to-face meeting to re-evaluate the treatment plan should be arranged and tapering the patient off opiate therapy should be considered. If the MEDD dose exceeds 80 to 90 mg, the patient should be educated about naloxone therapy. Naloxone, which has the brand name Narcan, is used to treat drug overdoses. Because sleep apnea, chronic respiratory illness, and concurrent benzodiazepine[2] usage also increase toxicity risks in opiate dependent patients, the naloxone antidote

[2] Benzodiazepines are a class of psychoactive drugs and type of sedative medication.

is strongly recommended for these patients. If functional improvements are not realized, the physician should strongly consider tapering the patient off opiate therapy.

33. Dr. Huang concluded that respondent departed from this standard of care in his monitoring of Patient A because he failed to properly assess Patient A's opiate addiction risks with appropriate scoring. His frequent alcohol use, addiction to tobacco, and his age, elevated this risk. A multidisciplinary approach would have been most appropriate involving primary care, a pain management specialist, surgery, and psychological cognitive behavioral therapy. Due to the risk of addiction, respondent should have tapered down Patient A's narcotic dosage to minimize risks of addiction. He did not consider tapering down the methadone or oxycodone but simply renewed the prescriptions. The MEDD was excessively high and too dangerous at 1,100 mg. If respondent was not comfortable tapering Patient A off the methadone, he should have had Patient A see a pain management physician sooner than October 2017, which was five months after respondent began treating Patient A.

34. With such a high dose of narcotics, respondent should have employed UDTs at least once or twice during the six-month treatment period to monitor for diversion or aberrant behaviors. Respondent did not, also, record that he monitored Patient A's narcotic history through CURES.

35. Dr. Huang also found a departure from the standard of care because respondent did not prescribe Patient A with naloxone to minimize or mitigate against the risk of overdose in light of the high MEDD Patient A was taking.

36. Dr. Huang wrote in his report that respondent committed an extreme departure from the standard of care, "in totality," due to these departures. He testified

that extreme departure means multiple simple departures or care that is so extreme compared to the standard of care it is no care at all. However, Dr. Huang did not state whether respondent's conduct constituted an extreme departure because it involved multiple simple departures or that his conduct was so extreme it was no care at all.

37. The next issue Dr. Huang identified related to respondent's evaluation and non-opiate pain management therapy. According to Dr. Huang, the standard of care is based on: the Medical Board's 2014 "Guidelines for Prescribing Controlled Substances for Pain," and the Centers for Disease Control and Prevention's (CDC) "Guideline for Prescribing Opioids for Chronic Pain-United States, 2016." These guidelines codified the physician management strategies in place at the time and served to identify the standards of care for opioid pain management to help physicians navigate the risks and benefits of chronic pain and chronic opiate therapy. Initial evaluation of chronic pain should include a complete history, physical exam, and appropriate testing. For non-cancer pain management, opiate therapy is not considered to be the first line of treatment due to the risks of addiction drug overdose and respiratory depression. Non-pharmacologic and non-opiate therapies are preferred. Non-opiate medications can often lessen pain and restore functionality. Surgical consultations are other options. Patients do not need to fail all these therapies before the narcotics are tried if the benefits outweigh the dangers. If opiate therapy is initiated, it is most beneficial when employed with non-opiate medications and non-pharmacologic therapies.

38. Dr. Huang believed the board's 2014 guidelines reflected the best medical practices. When published in 2014, much of what was mentioned in the guidelines were already in practice in the community and practiced by reasonable and prudent doctors.

39. Dr. Huang is familiar with the argument that the Guidelines do not represent the standard of care, which respondent's expert, Dr. Stenzel asserted. Dr. Huang disagreed and believed the Guidelines in 2014 reflect the standard of care for physicians treating patients with chronic pain. Dr. Huang stated the Guidelines were "not made up in a vacuum" but were created based on best practices, to highlight and emphasize for doctors.

40. Dr. Huang, based on his review of the records, found that respondent, in "totality," committed a simple departure from this standard of care because he did not make a more conscious effort to obtain Patient A's past records to justify continuing him on opiate therapy for the next six months. He should also have tried other non-opiate medications including selective serotonin reuptake inhibitors (SSRI), muscle relaxants and other medications to reduce Patient A's opiate dependency.

41. With regard to the third issue Dr. Huang identified, methadone usage in chronic pain management therapy, Dr. Huang stated that the standard of care requires that methadone therapy be the opioid medication of last resort and used only after other safer opioids have been tried.

42. Dr. Huang noted that methadone is a very powerful opioid: the most powerful opioid behind fentanyl, and it is five to twenty times more powerful than morphine. The drug has difficult pharmacokinetic effects. Methadone is only to be used as last resort. Methadone is considered the number one drug causing accidental overdoses behind fentanyl. Due to its long half-life, methadone is responsible for one-third of all prescription drug overdoses and deaths. While a special license is not required for prescribing methadone, it should only be prescribed by physicians who are aware of its pharmacokinetics and side effect profile. Importantly, methadone can result in a prolonged cardiac QT interval (a measurement in an EKG) which places

patients at risk of fatal cardiac arrythmias. Before therapy is initiated, a baseline EKG and periodic EKGs during therapy are advised.

43. Dr. Huang found that respondent committed a simple departure from the standard of care because he did not perform a baseline EKG before starting, or continuing, Patient A on methadone. He stated that Patient A had dizzy spells and falls, which could be related to methadone toxicity. Dr. Huang was aware that respondent had Patient A undergo an EKG in November 2017, at the end of the patient's treatment with respondent.

44. Regarding the use of Ritalin, Dr. Huang identified that the standard of care requires the physician to ensure that a proper diagnosis of ADHD has been made. Ritalin, an amphetamine, is one of the most widely abused drugs in the United States. Dr. Huang testified that many opiate addicts abuse stimulants to help maintain their alertness and allows them to achieve a euphoric high. Primary care clinicians are competent to make the ADHD diagnosis using a simple check list established by the World Health Organization. It takes five minutes to complete the questionnaire and patients who screen positive for this condition should have a more thorough interview regarding the symptoms and the functional impairments to ensure a proper diagnosis. Many primary care physicians request mental health consultations for this condition. Dr. Huang added that documentation that another provider prescribed Ritalin is not sufficient documentation that Patient A was assessed with ADHD.

45. Dr. Huang found that respondent committed a simple departure from this standard of care because respondent should have made greater effort to confirm the ADHD diagnosis, and he could have performed the ADHD screening questionnaire or consulted with a mental health professional. If he had Patient A's records, respondent would have been able to confirm the diagnosis if it were recorded in these

records. Notwithstanding, Dr. Huang did believe it was appropriate for respondent to initially refill the prescription at the first office visit.

TESTIMONY OF RESPONDENT'S EXPERT DR. STENZEL REGARDING RESPONDENT'S TREATMENT OF PATIENT A

46. Respondent called as an expert Loretta Sutphin Stenzel, M.D. Dr. Stenzel obtained her medical degree from Duke University School of Medicine in 1986. She is board certified in family medicine with an added qualification in geriatrics. Dr. Stenzel is Office Medical Director for Johns Hopkins Community Physicians in Maryland. From 2010 to 2019 she served as Director of Adult Medical Services, an FQHC, for the Vista Community Clinic in Vista, California. While she was Director at the Vista Clinic, Dr. Stenzel served on a county-wide task force to address the opioid crisis. From 2006 to 2010, Dr. Stenzel worked as a physician for FQHCs in Illinois and Texas. In her work at FQHC clinics, Dr. Stenzel managed a large case load of patients on opioid pain management therapy.

47. Dr. Stenzel reviewed the evidence of record and wrote a detailed report which was consistent with her testimony. Her testimony regarding Patient A is summarized as follows:

48. Dr. Stenzel identified the standard of care as the reasonable care a physician would perform in the same or similar circumstances. She emphasized that respondent's treatment, as measured by the standard of care, must be viewed as the care a reasonable physician would perform at a federally funded clinic with limited funding and resources. In discussing the standard of care regarding respondent's treatment of Patient A and the other three patients at issue in this matter, Dr. Stenzel said that respondent's care of all the patients should be reviewed in the context of the

resources available to him at a community clinic where specialty resources are limited, even with insurance, and patients lack resources to travel to specialists. Dr. Stenzel stated that physicians at these clinics are limited in their care and treatment of patients because they have difficulty obtaining medical records, scanning these records into patient charts, and obtaining referrals for specialty care.

49. In addition, regarding the applicable standard of care, Dr. Stenzel did not agree that the Medical Board's 2014 Guidelines represented the standard of care for managing opioid therapy patients. She testified that it takes time for a guideline to become the standard of care.

50. Dr. Stenzel concluded that respondent acted reasonably and met the standard of care she identified with regard to Patient A. In her summary of respondent's care of Patient A, she stated he reviewed CURES reports and conducted a pill count of Patient A, although he did not record this in Patient A's records. She accepted respondent's testimony that he reviewed CURES and conducted a pill count. Dr. Stenzel, further, with respect to the use of UDT, stated she did not believe respondent departed from the standard of care because she questioned the value of UDT screens, citing a CDC study published in March 2016. She added that the standard of care did not require more frequent UDTs based on the community standard. She cited the costs for community clinics in general for UDTs. However, the evidence of record does not show that this was a factor in respondent's decision to not conduct more frequent UDTs.

51. Dr. Stenzel found that respondent appropriately provided Patient A with the narcotic prescriptions before he made specialty referrals. Paradoxically, she felt that a referral "could not be reasonably accomplished," as she wrote in her report, in the "clinical and administrative setting in which [respondent] encountered this patient

at a community clinic." The "referrals could not have been processed without the benefit of the patient's past medical records," she wrote. Dr. Stenzel explained that a pain management specialist would not take over the care of a patient unless he or she had these records. Dr. Stenzel added that it was reasonable for respondent to wait until October 2017 to make the referral; the standard of care did not require him to make the referral sooner; it would not have been fruitful in her mind to refer Patient A to the pain management specialist without prior medical records.

52. Dr. Stenzel next found that respondent appropriately maintained Patient A on oxycodone and methadone as a "legacy patient." She commented that she had no problem with respondent's prescribing of methadone to Patient A, noting it is commonly prescribed in her experience, and is the least expensive option under the Affordable Care Act. She stated that prescribing the opioid and methadone was appropriate as respondent was trying to get Patient A to see a pain management specialist. Dr. Stenzel also found that respondent acted appropriately when he performed the EKG on Patient A in November 2017 after Patient A stated he was dizzy. She stated that the EKG was normal, and she did not see an increased risk of arrythmia.

53. As proof to her that respondent acted reasonably, Dr. Stenzel wrote that the narcotic medications were "beneficial" to Patient A, and Patient A suffered no harm "from the medications that were prescribed." It is not clear what Dr. Stenzel meant by "beneficial." But in any case, compliance with a standard of care is not based on whether or not a patient suffers harm.

54. Dr. Stenzel did not offer an opinion regarding the appropriateness of respondent's prescribing of Ritalin to Patient A, or his failure to assess Patient A for ADHD, as Dr. Huang discussed.

55. Dr. Stenzel next discussed respondent's treatment of Patient A after he suffered a head injury outside a bar where he tripped, fell, and was found unconscious. Dr. Stenzel found that respondent acted reasonably by maintaining him on the same drug regimen after the incident because "[Patient A] did not state that he was drinking or was otherwise intoxicated." Dr. Stenzel stated the emergency room report did not find that Patient A was intoxicated, and a laboratory test was not done to show Patient A had alcohol in his system, and alcohol intoxication was not included in the differential diagnosis.[3]

56. With regard to Dr. Huang's opinion concerning naloxone, Dr. Stenzel stated that the standard of care did not require respondent to prescribe naloxone in 2017, and he appropriately acted within his clinical judgment to not prescribe it. In her analysis, Dr. Stenzel discussed the history of naloxone use. In 2015, the Food and Drug

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[3] Respondent spent a considerable amount of time during the hearing arguing that Patient A was not intoxicated when he went to the hospital on July 10, 2017. Respondent, and Dr. Stenzel, both missed the larger concern Dr. Huang raised in his analysis. The record more than suggests that Patient A was abusing alcohol while he was taking high dose opioids, a concern, it is noted, respondent never recorded he addressed with Patient A. High dose opioids and abuse of alcohol are a deadly combination. Per the record, Patient A admitted he regularly drank alcohol. An audit respondent did of Patient A when he first saw him rated him at least with a possible alcohol abuse problem. Patient A was in a bar where alcohol was served, then he fell outside the bar. And a pharmacy worker was sufficiently alarmed that Patient A was under the influence of alcohol and smelled of alcohol on November 8, 2017, at the pharmacy that he or she contacted SDFC.

Administration (FDA) approved naloxone in nasal form.[4] The FDA had previously approved it in injectable form. The nasal form of this drug took time to circulate into general use and it was not until 2019 that naloxone prescriptions became a legal requirement for higher risk opioid therapy patients.

PATIENT B

57. On November 30, 2017, Patient B, a then 42-year-old female, saw respondent for the first time at the clinic. At this first visit with respondent, Patient B complained of back pain. She said a pain management specialist refused to see her because of insurance issues. Respondent assessed Patient B with chronic pain syndrome and lumbosacral radiculopathy due to degenerative disc disease. Per a questionnaire Patient B completed, she was described as suffering moderately severe depression. She has been receiving care at the clinic since at least 2013. According to a progress note dated October 23, 2013, Patient B had prescriptions for Ambien, Ativan, Adderall, Prozac, and tramadol at that time.[5] She was prescribed oxycodone on

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[4] Business and Professions Code section 741, effective January 1, 2019, requires providers to "offer" naloxone to certain patients receiving opioids.

[5] Ambien is the brand name for zolpidem tartrate, a sedative hypnotic and a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d). Ativan is the brand name for lorazepam, a benzodiazepine and a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d). Tramadol is an opioid used to treat moderate to severe pain and a Schedule IV controlled substance. Adderall is a stimulant and a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (d).

December 13, 2013. Respondent noted he reviewed Patient B's medication list and reconciled it with the patient. For respondent's plan, respondent referred Patient B for pain management due to refractory pain symptoms and continued Patient B on her current medications and therapy.

58. At this visit, respondent refilled Patient B's prescriptions for 10 mg of Ambien, 1 mg of lorazepam, to be taken three times daily, 350 mg of Soma, to be taken four times a day, 100 mg of gabapentin, 40 mg of Prozac, 30 mg of oxycodone, to be taken every four to six hours, and 30 mg OxyContin ER 12 Hour Abuse-Deterrent, to be taken every 12 hours.[6]

59. After the appointment, Patient B left a phone message that she wanted a behavioral health (BHI) appointment due to past domestic violence. She stated she would return for this appointment in the afternoon. However, Patient B did not return for the appointment.

60. As recorded in a telephone encounter note dated December 5, 2017, a pharmacist called the clinic to state he or she was not comfortable dispensing the lorazepam, Ambien, oxycodone, and Soma medications because Patient B had received these medications from three different providers.

61. On December 6, 2017, Patient B returned to the clinic and saw Jonathan Baker, M.D. She returned for follow-up regarding chronic pain and to have the Soma,

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[6] Soma is the brand name for carisoprodol, a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d). Gabapentin is an anti-convulsant and nerve pain medication. Prozac is the brand name for fluoxetine, a medication used to treat depression.

Ambien, lorazepam, OxyContin medications refilled. Patient B reported she was in good overall health, and able to do her usual activities. Dr. Baker assessed Patient B with chronic pain. He recommended to her that she taper down her controlled medications and go to the hospital if she started experiencing withdrawal symptoms. Dr. Baker noted that Patient B had an appointment with a pain specialist in two weeks.

62. The next day, December 7, 2017, Patient B returned to the clinic and saw respondent. At this visit Patient B signed a controlled medication agreement. Per this agreement, Patient B agreed to obtain her controlled substance medications from one provider and one pharmacy. On this date, Patient B filled a prescription written by respondent for 120 tablets of 30 mg oxycodone for a thirty-day supply, per CURES.

63. On December 21, 2017, Patient B filled a prescription written by Michael Keller, M.D., for 84 tablets of 30 mg oxycodone for a 14-day supply.[7] She obtained this drug from a different pharmacy than the one she used to fill prescriptions written by respondent.

64. Patient B returned to the clinic on January 3, 2018, and saw respondent for follow-up of medical issues after her visit with a rheumatologist. Respondent assessed Patient B with chronic pain syndrome and his plan involved waiting for input from a rheumatologist and a duplicate referral to a rheumatologist. Respondent refilled Patient B's prescriptions for 30 tablets of 10 mg Ambien, 90 tablets of 1 mg lorazepam, 150 pills of 100 mg gabapentin, 42 tablets of 30 mg oxycodone for a seven-day supply, and 60 tablets of 30 mg OxyContin.

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[7] Patient B's medical records include records from Dr. Keller's office. The clinic referred Patient B to Dr. Keller, who it appears, was a rheumatologist.

65. Per CURES, another provider, Raul Alicea, P.A., under Dr. Keller's supervision, wrote a prescription for 120 pills of 30 mg oxycodone for a 14-day supply, which Patient B filled on January 11, 2018. Dr. Keller also wrote a prescription for 126 pills of 30 mg oxycodone for a 21-day supply which Patient B filled on January 25, 2018. (Respondent's records include a progress note dated January 12, 2018, from PA Alicea that his plan was to continue Patient B on gabapentin and to refill her oxycodone prescription for two weeks).

66. In a progress note dated January 25, 2018, from the P.A. at Dr. Keller's office, Patient B was to be referred to a pain management specialist. Patient B asked for a three-week supply of oxycodone until she could see the specialist, and she reported that the gabapentin was providing no pain relief. On or about the same day, Patient B filled a prescription written by Dr. Keller, for 126 tablets of 30 mg oxycodone for a 21-day supply.

67. On January 30, 2018, Patient B returned to SDFC and respondent prescribed the medications in the same dosages and amounts. Patient B refilled the prescription for 350 mg of carisoprodol on January 31, 2018, and refilled the prescription for 120 pills of 30 mg oxycodone on February 2, 2018, for a 30 day supply. But, just seven days before she filled this prescription, as noted, at another pharmacy, Patient B filled a prescription from Dr. Keller for 126 pills of 30 mg oxycodone for a 21-day supply.

68. On January 31, 2018, Patient B also filled a prescription for 120 tablets of 350 mg carisoprodol from respondent. On February 15, 2018, Patient B filled a prescription written by respondent for 60 tablets of 30 mg OxyContin.

69. At Patient B's next clinic visit, on February 23, 2018, Patient B continued to complain of neck and back pain but reported the medications were "effective." Respondent assessed Patient B with chronic pain syndrome, adult physical abuse confirmed, degenerative joint disease, and cervicalgia. She was noted to be seeing a rheumatologist and pain management specialist with limited intervention at that point. Respondent referred Patient B to behavioral health and continued her on the medications "for now."

That same day, the pharmacy called respondent's office and reported that Patient B was seeking an early refill of oxycodone. Respondent's office denied this request.

70. On February 23, 2018, Patient B filled prescriptions written by respondent for 30 tablets of 10 mg Ambien and 30 tablets of 1 mg lorazepam. On February 25, 2018, Patient B filled a prescription written by respondent for 180 tablets of 30 mg oxycodone, which represented an increase from the 120 pills for a 30-day supply. The record does not document why respondent increased the number of oxycodone pills to 180 pills for a 30-day supply, especially considering at her appointment Patient B said the medications were effective.

71. On March 1, 2018, Patient B filled a prescription written by respondent for 120 tablets of 350 mg carisoprodol for a 30-day supply; on March 17, 2018, Patient B filled a prescription for 90 pills of 350 mg carisoprodol for a 23-day supply. Respondent also did not document why he issued a prescription of carisoprodol for a 23-day supply.

72. On March 16, 2018, Patient B returned to the clinic and saw respondent. In addition to her chronic neck and back pain, Patient B complained of increased thoracic pain. Respondent refilled Patient B's medications.

73. On March 17, 2018, Patient B filled prescriptions from respondent for 90 tablets of 350 carisoprodol and 60 tablets of 30 mg OxyContin. On March 18, 2018, Patient B filled prescriptions from respondent for 30 tablets of 10 mg Ambien and 30 tablets of 1 mg lorazepam. On March 19, 2018, Patient B filled a prescription respondent wrote for 180 tablets of 30 mg oxycodone.

74. According to CURES, on March 30, 2018, Patient B filled a prescription written by another provider, Nadine Batac, N.P., for 60 tablets of 15 mg oxycodone for a 15-day supply.

75. On April 9, 2018, Patient B filled a prescription written by respondent for 30 tablets of 350 mg carisoprodol, for an eight-day supply, and 30 tablets of 1 mg lorazepam, for a 10-day supply.

76. At Patient B's next appointment with respondent, on April 11, 2018, Patient B complained of pelvic pain and a rapid heart rate and reported little change in her condition. Respondent refilled Patient B's medications. That day, Patient B filled prescriptions written by respondent for 120 tablets of 350 mg carisoprodol and 180 tablets of 30 mg oxycodone. On April 16, 2018, Patient B filled the prescription for 60 pills of 30 mg OxyContin written by respondent.

77. On May 3, 2018, Patient B returned to the clinic and saw respondent. Respondent noted that little progress had been made with pain management and rheumatology consultations, and that Patient B was to have a neurosurgery consult. Respondent ordered lumbar and cervical spine MRIs.

78. On May 4, 2018, Patient B filled prescriptions respondent wrote for 30 tablets of 10 mg Ambien and 90 tablets of 350 mg carisoprodol. On May 6, 2018, Patient B filled a prescription respondent wrote for 90 tablets of 30 mg oxycodone. On May 16, 2018, Patient B filled a prescription from respondent for 60 tablets of 30 mg OxyContin. On May 27, 2018, Patient B filled a prescription written by respondent for 30 tablets of 350 mg carisoprodol.

79. On May 30, 2018, Patient B went to a pain management specialist through Synovation Medical Group. Patient B wanted a second opinion regarding surgery and said she wanted to be weaned off of OxyContin. She was advised if she wanted to be weaned off of the opioids, her primary care doctor could do this, and she should talk to him.

80. On June 1, 2018, Patient B returned to the clinic to see respondent. She reported that the pain medicine consult did not take her insurance. Testing through rheumatology was still under way. Respondent's plan was to wean Patient B's narcotic therapy. He gave Patient B prescriptions for 60 tablets of 30 mg OxyContin and reduced the quantity of 30 mg oxycodone from 180 pills to 120 pills for a 30-day supply, with half a tablet of oxycodone to be taken every six hours as needed.

81. A note on June 1, 2018, indicated Patient B wanted an appointment to see a behavioral health specialist. It was noted under the "action taken" section of the note that Patient B did not attend scheduled behavioral therapy appointments in November and March.

82. A note from June 7, 2018, indicated that Patient B wanted to see a therapist for trauma and depression because she was the victim of violent physical abuse by her ex-husband that resulted in multiple surgeries. She reported she had not

seen a behavioral therapist because she did not think she needed one; she had not seen a psychiatrist since 1999. The clinic scheduled her to see a psychologist on June 11, 2018. She was also given information for the Family Justice Center to obtain legal and other services for domestic violence.

83. On June 8, 2018, Patient B filled the prescription for 120 tablets of 30 mg oxycodone and on June 15, 2018, Patient B filled the prescription for 60 tablets of 30 mg OxyContin.

84. On June 26, 2018, Patient B called respondent's office and requested prescription refills, including a prescription for lorazepam. Patient B was reminded that the plan was to taper down her medications, and that she needed to make an appointment with her primary care physician for the refills.

85. On June 28, 2018, Patient B returned to the clinic and saw respondent. She was noted to have rheumatology and neurological consults within the month and was scheduled for behavioral health intake. Patient B wanted medication refills, including a refill for lorazepam. Respondent refilled her medications and increased the oxycodone to 180 pills from 120 of 30 mg oxycodone per month. Respondent also issued her a prescription for 30 pills of 1 mg of lorazepam.

86. Patient B filled a prescription for 30 tablets of 1 mg lorazepam. On June 29, 2018, Patient B filled the prescription for 180 tablets of 30 mg oxycodone. On July 23, 2018, Patient B filled a prescription from respondent for 30 tablets of 10 mg Ambien.

87. Patient B next saw respondent on July 26, 2018. This was Patient B's last appointment with respondent. Patient B reported the medications were effective, but the neck/back pain persisted. Respondent referred Patient B to an acupuncturist for

worsening symptoms. Respondent gave Patient B a refill prescription for 180 tablets of 30 mg oxycodone. Patient B filled respondent's prescriptions for 120 tablets of 350 mg carisoprodol and 180 tablets of 30 mg oxycodone. On July 30, 2018, Patient B filled a prescription respondent wrote for 30 tablets of 1 mg lorazepam.

88. On August 8, 2018, the pharmacy contacted respondent's office regarding a request for Patient B's CURES report, respondent's progress note, and a supporting statement from respondent to justify the prescription. Per Patient B's health plan, Patient B had been picking up oxycodone and OxyContin ER and IR from eight different pharmacies.

89. On August 8, 2018, Patient B failed to appear for a scheduled appointment with respondent. Patient B was notified by letter that she needed to make an appointment to receive any refills on her medications.

90. Respondent, during the time he treated her from December 7, 2017, through August 2018, did not significantly taper her opioid medications and continued to prescribe Soma and lorazepam to her.

TESTIMONY OF DR. HUANG REGARDING RESPONDENT'S TREATMENT OF PATIENT B

91. Dr. Huang identified that respondent departed from the standard of care relating to the following medical issues in his care and treatment of Patient B: initiation and monitoring of chronic opiate therapy; management of general anxiety disorder by primary care physician (identified in accusation as failure to document long term use of lorazepam); concurrent use of benzodiazepines and opiate therapy; and management of insomnia by primary care physician.

92. With regard to the first issue, initiation and monitoring of chronic opiate therapy, the standard of care is identified above in the summary regarding Patient A. Dr. Huang found a simple departure from this standard of care because respondent did not perform an initial ORT assessment of Patient B's addiction potential. In Dr. Huang's view, due to depression, domestic violence, and her young age, Patient B scored high on the opioid addiction risks. In addition, he found departures from the standard of care also because respondent did not taper down her narcotic dosage and did not administer UDT to her.

93. With regard to the next issue, respondent's management of generalized anxiety disorder, Dr. Huang identified the standard of care to require the primary care physician, as the patient's first contact, to assess the severity and extent of the functional impairment caused by the anxiety disorder, and with a patient's input, decide on approaches which include therapy and/or medications. Medications include SSRI antidepressants or a serotonin norepinephrine reuptake inhibitor (SNRI), which are the best studied medications found to be efficacious to treat anxiety. Benzodiazepines can be effective in treatment of anxiety, but concerns about risks of dependency and tolerance have limited their use.

Dr. Huang found that respondent departed from this standard of care because he prescribed lorazepam to Patient B but never documented the indication for this therapy and he did not perform a thorough review of Patient B's anxiety disorder. He just prescribed the addictive benzodiazepine monotherapy.

94. Regarding the next issue he identified, the concurrent usage of benzodiazepine and opiate therapy, Dr. Huang articulated the standard of care as follows: benzodiazepines and opiates both cause central nervous system depression and can decrease respiratory drive. Clinicians should strongly avoid prescribing both

narcotics and benzodiazepines at the same time because the risks outweigh the benefits. Concurrent use is likely to put patients at risk for potentially fatal overdoses per expert review of epidemiologic data. The increase in overdose deaths was well known before the board's 2014 publication. When faced with a patient prescribed both narcotics and benzodiazepines, the physician should taper the patient off the opiate first. If the patient wants to continue opiate therapy, the physician should slowly taper the benzodiazepine. The taper should be slow and gradual for a patient taking the benzodiazepine for anxiety. Other anti-depressants and non-benzodiazepine medications should be offered. Consultation with psychiatry for cognitive behavioral therapy is also vital to the success of tapering.

Respondent departed from this standard of care because of Patient B's high narcotic dosage, and the daily dose of lorazepam clearly exposed her to increased risk of accidental death from overdose of the combination. In his view, respondent should have weaned her off of one of these medications to minimize the risk. Naloxone should also have been prescribed to mitigate the risk of an overdose. The departure, he found, was a simple departure from the standard of care.

95. Next, Dr. Huang found that respondent committed a simple departure from the standard of care in the management of insomnia by primary care physician. He articulated this standard of care as follows: Ambien is the drug a physician should try as a last resort. If Ambien is used long term, its side effects and dangers are similar to benzodiazepines. The main modalities of treatment of insomnia are psychological/behavioral therapies, pharmacologic treatment, or a combination. Confirmation of insomnia involves a detailed history and physical exam. The history should include use of a sleep diary and interviewing the patient's partner to assess the severity of insomnia. A review of medications should be done to identify medications

that can cause insomnia. A physical examination can often elicit medical causes of insomnia including obstructive sleep apnea.

If pharmacotherapy is chosen, physicians should always avoid benzodiazepines or Ambien due to their addiction potential and side effects from long term usage. Other safer medications should be tried like trazadone and tricyclic antidepressants if the insomnia is associated with depression.

Dr. Huang found that respondent committed a simple departure from this standard of care. In his analysis he noted that Patient B was prescribed Ambien in 2013 and 2014 and most likely developed an addiction to the drug by 2017 when she first saw respondent. Respondent should have avoided adding Ambien to an already dangerous combination of oxycodone and lorazepam. All three of these medications could cause accidental respiratory failure. Respondent should have tried to wean her off of the drug and tried safer alternatives. In Dr. Huang's view, Patient B's insomnia was probably due to depression, and he commended respondent for referring her for mental health treatment.

TESTIMONY OF DR. STENZEL REGARDING RESPONDENT'S TREATMENT OF PATIENT B

96. Dr. Stenzel testified that respondent met the standard of care in his care and treatment of Patient B in all respects in managing the complexities of problems and challenges Patient B posed. She opined that respondent reasonably managed this patient with the limited resources available to him. In her analysis, Dr. Stenzel stressed that Patient B was a long-term clinic patient whose care other providers managed for chronic pain with opioid, benzodiazepines, and muscle relaxants for five years before she treated with respondent. She commented that Patient B was highly tolerant of the

pain medications she was taking and was able to maintain a reasonable quality of life on the medications she was taking. She noted further that CURES documented respondent provided medications in the same amounts as other providers. Respondent, further, confirmed the sources of pain from the physical examination he performed and from the records he reviewed.

TESTIMONY OF DR. NICOLAS BADRE REGARDING RESPONDENT'S TREATMENT OF PATIENT B

97. Respondent called Nicolas Badre, M.D., a forensic psychiatrist, to testify regarding respondent's prescriptions of lorazepam and Ambien to Patient B and his prescriptions of benzodiazepines to Patient C. Dr. Badre obtained his medical degree from the University of Kentucky. He is the director of forensic training at the University of California San Diego, and he teaches a course in psychopharmacology at the University of San Diego. He is the author of 40 articles in academic and mainstream publications in the field of psychiatry. His forensic work involves court ordered evaluations through the forensic evaluation unit of the County of San Diego. He also has conducted fitness for duty examinations of physicians and health professionals and has served as a board expert. He maintains a small clinical practice where he spends about 10 to 20 percent of his time treating about three to four patients a week.

98. Dr. Badre was asked to testify in his capacity as a forensic psychiatrist and not as an expert in primary care. He reviewed the materials of record regarding Patient B and he prepared a report which was received into evidence. His testimony was consistent with what he wrote in his report.

99. Dr. Badre found that given Patient B's circumstances as a victim of domestic violence, and her long-term use of benzodiazepines and Ambien, it was

prudent and reasonable for respondent to prescribe these medications to her. He wrote in his report that it was not apparent to him that tapering her medications, in a period of less than a year when respondent was seeing her, would have been a wise intervention.

100. The significant complicating factor for Dr. Badre was that Patient B was a victim of domestic violence. It would have been inappropriate to reduce her medications as Dr. Huang opined; reducing them would have been very dangerous in his view due to her dependence on the medications and her mental health struggles due to her history as a victim of domestic violence. Dr. Badre added he was unable to say whether starting Patient B on benzodiazepines, Ambien and opioids was appropriate in the first place.

101. Regarding the lorazepam prescription, Dr. Badre opined that the prescription was appropriate because respondent was simply continuing the prescription she had in the past (which he noted ended March 17, 2016, before she saw respondent) because, he speculated, Patient B may have had a supply of lorazepam from past prescriptions and respondent reconciled her medication list with Patient B. The point Dr. Badre was trying to make here is not clear. Dr. Badre acknowledged, in response to a question on cross-examination, respondent did not document why he added lorazepam, and he did not evaluate Patient B for anxiety.

102. With regards to respondent's prescription of Ambien to Patient B, Dr. Badre stated that the drug is not as addictive as opioids.

103. Dr. Badre emphasized respondent appropriately referred Patient B to rheumatology, behavioral health, and the Family Justice Center.

PATIENT C

104. Patient C began treating with respondent on June 17, 2016, when she was 55 years old. She had been a clinic patient since 2010. Patient C had numerous medical and psychiatric problems including anxiety, bipolar disorder, depression, and chronic pain. Her left leg and half her pelvis were amputated in 2002 due to a bacterial infection, and she was diagnosed with Type II diabetes. For many years was taking pain medications for phantom limb pains. She also had gunshot shrapnel from a self-inflicted gunshot wound in her left chest with a partial lobectomy.[8] In July 2012 Patient C had a spinal cord stimulator placed, which was removed in November 2018. Respondent was also prescribed a ProAir inhaler to use every four to six hours, and she was a smoker. Patient C was noted to have chronic obstructive pulmonary disease (COPD). During the course of her treatment with respondent, she was counseled regarding smoking and prescribed a nicotine patch to help her quit. Patient C had signed controlled medication agreements at the clinic.

105. During the period at issue in this matter, July 17, 2016, through September 2018, respondent prescribed to Patient C 90 pills of 200 mg extended release (ER) morphine sulfate and 90 pills of 30 mg immediate release (IR) morphine sulfate. In January 2018 he reduced the dosage of ER morphine to 100 mg and further reduced the dosage of ER morphine to 60 mg in April 2018. He stopped prescribing

[8] On February 8, 2019, Patient C was hospitalized for acute respiratory failure. At the time she was under the care of David Smith, M.D., a pain management specialist, and after respondent stopped treating Patient C.

controlled substances to Patient C starting in September 2018; other providers prescribed ER and IR morphine to her.

106. When Patient C began seeing respondent in June 2016, her previous doctor, Joseph Risser, M.D., prescribed her 60 pills of 200 mg of the ER morphine and 90 pills of the 30 mg IR morphine. This was 690 mg MEDD as calculated by Dr. Huang. Her psychiatrist, Paul Strauss, M.D. prescribed her 90 pills of 5 mg of diazepam, 120 pills of 2 mg clonazepam, 30 pills of 12.5 mg Ambien, and 90 pills of 350 mg Soma.[9] In late 2017 Dr. Strauss died, and respondent prescribed diazepam to her and later another benzodiazepine, temazepam, as discussed below.

107. At Patient C's first visit with respondent on June 17, 2016, respondent assessed her with chronic pain and continued Patient C on the ER and IR morphine. Dr. Strauss continued her on the Soma, Ambien and benzodiazepines.

108. At Patient C's October 18, 2016, appointment, he had Patient C undergo a UDT which was positive for the medications she was taking and not indicative of aberrant behavior. At this visit a nurse or medical assistant recorded that he/she advised respondent that Patient C's oxygen saturation level was low.

109. On January 20, 2017, respondent referred Patient C for a neurosurgery consult to assess the nerve stimulator. He also referred her for a pain medicine consult.

110. At her April 20, 2017, visit with respondent, Patient C told respondent she didn't go to her pain medicine consult because she "was doing fine" on the narcotics

[9] Diazepam and clonazepam are benzodiazepines.

she was taking. The record documents that her husband was the recipient of a liver transplant and increased stress was noted.

111. On June 20, 2017, Patient C called and talked to respondent's nurse to report that the pain medicine doctor respondent referred her to wanted to advise respondent that due to Patient C's opioid levels at the time, Patient C needed to see an addiction specialist. The nurse advised respondent, who noted the information.

112. A note dated September 11, 2017, documents that Patient C was hospitalized with complaints of stomach pain and nausea. A CT scan was done of her abdomen, pelvis, and chest, and a lung mass was seen and a biopsy performed to rule out an infection, scar tissue, or malignancy. She was noted to have obstructive pneumonia. She was referred to the pulmonology clinic. Patient C was also referred for gastrointestinal, cardiac and psychiatric assessments. The physician, the note further records, wrote that Patient C was "very malnourished" due to opioid induced constipation.

113. Respondent recorded the hospital visit and Patient C's treatment for lung issues at her next appointment September 12, 2017. He continued her on the same dosages of amounts of IR and ER morphine. The record indicates she was receiving home health care and had a caregiver.

114. Patient C returned to see respondent on September 20, 2017. She noted she was feeling better and the pain was controlled. Patient C asked for follow up referrals for pulmonology and cardiology.

115. During a November 9, 2017, appointment with respondent, Patient C told respondent that the lung nodule was thought to be scar tissue. She refused to have her sugar level read because she said she did not have diabetes anymore.

116. On December 1, 2017, Patient C's husband took her to Scripps Mercy Hospital due to increasing confusion, involuntary body movements, and diffuse abdominal pain. She was admitted with acute dystonic reaction.[10] Because Patient C was reported to be an unreliable historian, information about her condition and history were obtained from her husband. She indicated she stopped taking medications prescribed by her psychiatrist who she said had quit. (In fact, he died in late 2017.) The emergency room consulting neurologist doctor assessed her with acute encephalopathy and acute dystonic reaction possibly from missing dosing of her medications. The neurologist also wrote that Patient C was on "abundant pain medications" and "some of these may have been taken inappropriately." Patient C was discharged on December 8, 2017.

117. In Patient A's discharge assessment, the clinicians agreed that Patient C decompensated due to discontinuation of her medications. She was restarted on her medications and her husband was consulted. Her husband stated that with a new psychiatrist, he did not feel medication compliance would be an issue in the future.

118. After her discharge from Scripps, Patient C saw respondent on December 12, 2017. He noted her psychiatrist had died and she had an abrupt withdrawal from not taking the medications he prescribed. Respondent made an urgent referral for Patient C to see a psychiatrist. He issued prescriptions for the IR and ER morphine and a prescription for diazepam, per CURES. He continued to issue prescriptions for IR and ER morphine and diazepam through August 2018. He added prescriptions for 30 pills of 30 mg temazepam in July and August 2020.

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[10] Dystonic reactions are involuntary muscle contractions.

119. Starting in January 2018, respondent reduced the dosage of ER morphine to 100 mg, to be taken every eight hours.[11] Starting March 23, 2018, respondent reduced the dosage of ER morphine further 60 mg, 1 to 2 tablets, every eight hours. On May 30, 2018, respondent started Patient C on temazepam 30 mg to be taken once daily. In his progress noted dated July 13, 2018, respondent documented that his plan was to continue to wean Patient C off narcotic medication. In the August 8, 2018, progress note, respondent documented that Patient C was to have pain medicine and psychiatric consults in the coming weeks. Respondent stopped prescribing controlled substances to Patient C in August 2018. Per CURES, other providers prescribed IR and ER morphine to her.

120. Per the September 12, 2018, progress note, Patient C had two pain management consultations, but insufficient records were provided for pain management. She continued to have chronic pain issues and respondent noted he was concerned about the small reduction in IR morphine. The neurostimulator was scheduled to be removed on November 1, 2018.

121. As discussed above, respondent stopped prescribing controlled substances to clinic patients effective September 2018. As recorded in CURES, beginning November 2018, other providers prescribed morphine to Patient C.

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[11] It appears Patient C signed a controlled medication agreement on January 12, 2018, though the date is somewhat illegible. Respondent also ran CURES reports for the 2016 to 2018. These reports are part of Patient C's chart.

TESTIMONY OF DR. HUANG REGARDING RESPONDENT'S TREATMENT OF PATIENT C

122. Dr. Huang identified the following medical issues where he found departures from standards of care: monitoring of chronic opiate therapy, and concurrent usage of benzodiazepine and opiate.

123. The standard of care Dr. Huang identified for the management of chronic opiate therapy is recited above.

124. Dr. Huang in his analysis regarding respondent's compliance with this standard of care recognized that respondent was a very challenging patient and respondent tried unsuccessfully to wean her narcotic dosages to safer levels. He commented that pain specialists did not provide much support in this regard. In June 2017, the pain specialist recommended that Patient C's primary care physician taper down her opioid medications.

But, in totality, Dr. Huang found that respondent committed a simple departure from the standard of care because respondent did not provide Patient C with a naloxone prescription, and he administered only one UDT to her in October 2016. Dr. Huang noted that Patient C had tobacco-related lung disease and used inhalers. Patient C's excessively high narcotic dosage increased her risk of an accidental overdose.

125. Regarding the next issue, concurrent use of benzodiazepines and opiates, the standard of care is discussed above with respect to Patient B. Dr. Huang concluded that respondent committed a simple departure from the standard of care by prescribing to Patient C diazepam and temazepam with excessively high dose opioids.

Dr. Huang stated that Patient C's depression and anxiety could have been managed safely without long term benzodiazepines.

TESTIMONY OF DR. STENZEL REGARDING RESPONDENT'S TREATMENT OF PATIENT C

126. Dr. Stenzel found that respondent met the standard of care in his care and treatment of Patient C in all respects. With regard the concurrent usage of benzodiazepines and opioids, Dr. Stenzel testified that while it was optimal to not combine benzodiazepines and opioids, at the time, it was not below the standard of care to prescribe the combination of drugs. She stressed that respondent "inherited" Patient C, and he exercised appropriate clinical judgment by prescribing the benzodiazepines for anxiety with opioids while waiting for specialty evaluation and treatment. It was not below the standard of care to continue the diazepam Dr. Strauss had prescribed to maintain her until she could be seen by a psychiatrist. She noted that respondent made timely referrals to specialists. Dr. Stenzel commented that pain management doctors in her experience are reluctant to take on the management of patients unless they have the medical records and clinics have difficulty obtaining these records.

127. With regard to Dr. Huang's criticism of respondent that he did not employ more frequent UDTs, Dr. Stenzel disagreed with his criticism. She stated respondent could not have been reasonably expected to refer Patient C for more frequent UDT and Patient C did not appear to be abusing the medications or engaging in aberrant behavior. Her pain was relatively well-controlled, she added.

128. Regarding naloxone, as discussed earlier, Dr. Stenzel did not believe the standard of care required respondent to prescribe naloxone to Patient C because the

standard of care at the time did not require naloxone for Patient C, or for any of the patients in this matter. She added that COPD is not a lung condition that would require the use of naloxone.

TESTIMONY OF DR. BADRE REGARDING RESPONDENT'S TREATMENT OF PATIENT C

129. Dr. Badre concluded that respondent did not depart from the standard of care when he prescribed benzodiazepines to Patient C. He stressed that respondent appropriately continued to prescribe benzodiazepines to Patient C after her psychiatrist died and she stopped taking the benzodiazepines and was hospitalized due to withdrawal. Abrupt withdrawal from taking benzodiazepines can be dangerous. In fact, he stated respondent may have committed a departure from the standard of care had he stopped prescribing benzodiazepines to her. Dr. Badre noted that respondent acted reasonably both in his prescribing of the benzodiazepines to Patient C and making timely referrals to specialists.

PATIENT D

130. Patient D was an SDFC patient since 2010 and first saw respondent on June 29, 2016, when he was 45 years old. He had numerous medical issues: diabetes, neuropathy, obesity, and depression. On June 9, 2015, his right leg was amputated below the knee. Patient D suffered from chronic pain due to neuropathy and phantom pain from the below the knee amputation, and was prescribed medications for pain. Patient D was also prescribed an inhaler for chronic lung and breathing issues.

131. His prior doctor at SDFC, Dr. Risser, prescribed monthly high dose opioids, morphine sulphate ER (brand name MS Contin), oxycodone, and hydrocodone

bitartrate with acetaminophen (brand name Norco). Dr. Huang calculated that Patient D was taking 540 mg MEDD daily.

132. Respondent assumed the care of Patient D on June 29, 2016. Patient D was a challenging patient to treat due to his resistance to pain management and his history of non-compliance with medical treatment, which in respondent's view presented hazards to Patient D's health, as respondent wrote in a January 4, 2018, progress note.

133. After assuming the care of Patient D on June 29, 2016, respondent recognized Patient D's opioid regimen needed to be aggressively tapered and a referral made to pain management. At this first visit, he referred Patient D for pain management and for a possible spinal implant. He also referred Patient D for surgical consultations. As an indication of the priority respondent placed on the pain management referral for Patient D, respondent emailed clinic staff on August 19, 2016, inquiring about the status of the pain management referral.

134. Starting July 2016, respondent reduced the oxycodone dosage to 240 mg daily and MS Contin to 300 mg daily. Within 12 months, respondent reduced oxycodone dosage to 120 mg daily with the MS Contin dosage remaining at 300 mg daily. By July 2018, respondent reduced the oxycodone to 30 mg daily with MS Contin remaining at 300 mg daily. Dr. Huang calculated the MEDD at 390 mg. Respondent discontinued the Norco prescription as an active prescription when he began treating Patient D.

135. Dr. Huang testified that respondent's efforts to taper down Patient D's very high narcotic dosage were truly commendable; he did not fault respondent for his prescribing of opioids to Patient D. He did, however, as discussed more fully below,

fault respondent for ordering just two UDTs over a two-year period and not prescribing naloxone, which are the departures he found in respondent's care and treatment of Patient D.

136. Patient D was a challenging patient for any physician to manage his chronic pain condition and therapy. Patient D resisted pain management and tapering of his medications. On August 23, 2016, he called the clinic to ask to increase the number of morphine pills respondent prescribed. Patient D said 90 pills were not enough. After a referral was made to a pain management specialist, Patient D told a staff person at the office of this pain management physician, Michael Verdolin, M.D., he was only making the appointment "to placate the evil Dr. Collins [*sic*] who is scared to prescribe the medications I need. ....." Patient D also told staff at this office that he would only attend the consult and would refuse treatment in order "to receive his narcotics." Dr. Verdolin was willing to see Patient D, nonetheless, and asked Patient D for imaging studies, which respondent facilitated, before he would see the patient.

137. Patient D saw respondent on December 8, 2016, and respondent discussed Patient D's concerns about tapering his medications and discussed with him at length, specifically, the need to reduce narcotics and look to other pain control methods. Patient D told respondent he was taking about six oxycodone pills a day. After this visit, Patient D complained to the clinic's medical director, Dr. Baker, about respondent on December 8, 2016.

138. Notably, within a week of this visit, on December 13, 2016, Patient D wanted an early refill of oxycodone, which respondent denied.

139. On December 21, 2016, Patient D called and requested a refill for his morphine sulfate prescription, saying he would be out of the medication the following day. Respondent gave Patient D refills for his medication.

140. At Patient D's October 6, 2017, appointment with respondent, respondent documented that Patient D was concerned about tapering his narcotics; he said he was comfortable on previous therapy. Patient D continued, respondent wrote, to resist reduction in narcotics and alternative pain control interventions.

141. On October 30, 2017, November 6, 2017, and December 4, 2017, Patient D called for early refills of morphine and oxycodone. He told the nurse on the call on November 6, 2017, he had to take extra medication for break-through pain.

142. On January 4, 2018, as noted above, Patient D returned to the office and saw respondent. Respondent noted Patient D's "personal history of noncompliance with medical treatment presenting hazards to health." He gave Patient D prescriptions for morphine sulfate and lowered the 15 mg oxycodone prescription from 90 to 60 tablets.

143. On January 26, 2018, Patient D called respondent's office very upset and requested early refills. Respondent noted in the email string that Patient D was not due for a refill until February 3, 2018, since the oxycodone and morphine were dispensed on January 4, 2018.

144. On February 26, 2018, Patient D called for an early refill of the oxycodone and morphine, which he said he would run out by March 2, 2018. The nurse reminded him he needed to sign an updated controlled medication agreement.

145. On March 6, 2018, Patient D returned to the office and saw respondent. Respondent refilled Patient D's medications and ordered a physical therapy referral.

146. On March 26, 2018, Patient D called for early refills of the oxycodone and morphine.

147. At Patient D's April 4, 2018, visit, Patient D submitted to a urine drug screen, which was, as expected, positive for opiates, morphine, morphine metabolites, oxycodone, and oxycodone metabolites.

148. On May 31, 2018, Patient D called the clinic to advise respondent he was admitted to the hospital and was to be discharged that day. He wanted a refill of the oxycodone and morphine prescriptions because he had medications for just another four days. Respondent advised Patient D he should have his post discharge medications addressed at the hospital and schedule an office visit with respondent.

149. On July 18, 2018, Patient D contacted the clinic for a refill of his medications because he was going to be out of them the next day. Patient D stated he was in a nursing home for post-hospital acute care.[12] Respondent refilled the medications but advised Patient D after August 9, 2018, he would no longer be prescribing these medications to Patient D. In a note documenting a call from the pharmacy dated July 20, 2018, the pharmacy indicated that Patient D did not want the

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[12] Patient D reported his stepfather was available to pick up the prescriptions for him. During the hearing respondent argued that naloxone would not be effective in counteracting an accidental overdose unless the person has someone who can administer the drug if there was an accidental overdose. It appears from this note that Patient D had the support of relatives in his treatment.

oxycodone and morphine dispensed to the skilled nursing facility but would pick up the prescription.

150. On August 7, 2018, Patient D's health plan contacted the clinic to advise respondent that Patient D wanted a pain management referral for his pain medications. Respondent facilitated the referral.

151. Patient D saw respondent on August 20, 2018, for follow-up post hospitalization. Respondent documented that Patient D was hospitalized with a blood clot in his lungs, urinary obstruction, and abscesses. Patient D asked respondent to authorize home health care.

152. On September 27, 2018, Patient D contacted the clinic to request a refill on his medications. Respondent advised Patient D of the controlled substance abuse policy and he would not issue prescriptions for the oxycodone and morphine.

153. At Patient D's October 2, 2018, visit with respondent, he requested refills of morphine and oxycodone. He said he saw a pain management specialist, John Qian, M.D., and needed a referral for neurological and psychological consultations, per a report from Dr. Qian dated September 18, 2018. Respondent issued Patient D a prescription for 120 pills of 50 mg tramadol. The record documents that Patient D underwent a pain management consultation and evaluation on September 18, 2018, based on respondent's referral.

154. Patient D called the clinic and spoke with Dr. Baker. In that call Dr. Baker recommended to Patient D he see a pain specialist. Dr. Baker said Patient D refused antidepressant and anticonvulsant pain medications. Dr. Baker also gave him emergency room precautions.

155. Respondent ordered UDTs of Patient D in October 2016 and on March 7, 2017.

TESTIMONY OF DR. HUANG REGARDING RESPONDENT'S TREATMENT OF PATIENT D

156. Dr. Huang testified that respondent committed a simple departure from the standard of care previously identified when he failed to conduct more frequent UDT screens to monitor for diversion and when he did not prescribe naloxone to Patient D because Patient D had chronic lung disease.

TESTIMONY OF DR. STENZEL REGARDING RESPONDENT'S TREATMENT OF PATIENT D

157. Dr. Stenzel testified that respondent did not violate the standard of care with respect to ordering UDT or with respect to prescribing naloxone for the reasons noted earlier.

Respondent's Testimony

158. Respondent's testimony is summarized as follows:

159. Respondent obtained his medical degree in 1994 from Rush Medical College in Chicago. He completed a residency in internal medicine in 1997. Respondent served as an attending physician in internal medicine at Rush University Medical Center from 1997 to 2004. For his work at Rush University, the board of trustees of the university approved in 2017 his change of status to emeritus. From 2006 to 2014 respondent was Medical Director for Interventional Pain Management. From 2014 to 2016 respondent was Medical Director/Section Head for the Veterans

Administration Clinic in Escondido, California. From 2016 to 2020 respondent was employed at SDFC. Since 2020, respondent has been employed as Medical Director of California Commercial Utilization Management Case Review for Anthem Blue Shield. Respondent is board certified in internal medicine and until 2018 was board certified by the American Academy of Integrative Pain Management. Respondent is not treating or caring for patients. In 2006 respondent obtained a master's degree in public policy with a concentration in health care policy.

160. Respondent testified the patients at issue in this matter were legacy patients because they had seen physicians previously for pain management. Regarding his treatment of these pain management patients, respondent said Dr. Baker, SDFC's then Medical Director, asked him if he was willing to take over the care of patients on high dose opioids. He reluctantly agreed. Respondent, however, effective July 8, 2018, implemented a change in his policy of prescribing addictive medications including opioids, some benzodiazepines, and Adderall. On that date he stopped prescribing these controlled substances to patients and instead advised them that he would refer them for pain management or psychiatric care. Respondent provided one month of bridge medications for these patients.

161. In terms of his care of pain management patients in general, respondent said he always advised them of the risks and benefits of narcotics and tried to taper their pain medications and provide them with alternative therapies.

162. Respondent stated that his ability to adequately treat and care for pain management patients was limited because SDFC lacked resources to address the medical problems of the largely underserved and underinsured population it served. He specifically noted SDFC's trouble obtaining the past medical records of patients. He said this affected his ability to obtain specialty consultations for patients.

163. Respondent also said that he always checked CURES for the pain patients he saw but CURES reports, due to SDFC's limited resources, were not always scanned into patient records. Respondent, in addition, said he conducted pill counts when pain patients saw him and conducted pill counts for all of the patients in this matter. He did not, however, record in the progress notes that he reviewed CURES reports or conducted pill counts.

164. Regarding his care and treatment of the patients at issue in this matter, respondent first discussed his care and treatment of Patient D.

Respondent said he explained to Patient D the risks of opioid therapy. But Patient D was defensive and not interested in tapering, and he had no interest whatsoever to change to safer alternatives to high dose opioids. Regardless, respondent, referred him to Dr. Verdolin and later to Dr. Qian. As a matter of his practice, when respondent first saw any pain management patients, he would ask the nurse for the CURES report and the report was handed to him; he would put the reports in the file at the clinic, but the reports would not always appear in the medical records. Respondent said he confirmed the medications Patient D was taking based on the CURES report he obtained from the nurse and based on the pill count he conducted. To corroborate his practice of reviewing CURES reports, respondent submitted into the record a copy of a search of CURES reports he conducted through the CURES system for seven different patients during the period between September 18, 2017, and November 11, 2017.

165. Regarding conducting UDT screens, respondent said he believes they are of little clinical value and provide little information. It will show a substance but not the level of the substance. The UDT screen will not tell him if the patient is diverting.

166. With regard to prescribing naloxone to Patient D, respondent stated as a general matter none of the patients at issue in this matter were interested in naloxone. Respondent did not believe they would overdose. He added that with naloxone, you are relying on someone to administer it during an overdose.

167. In accordance with this policy, respondent prescribed Patient D tramadol and made pain management referrals for him.

168. Regarding his care and treatment of Patient C, respondent described her as a very challenging patient. Patient C had significant psychiatric issues and resisted change. When he first began treating her, respondent conducted a pill count and reviewed CURES. Respondent stressed he tapered her morphine and referred her to pain management and to an addiction specialist.

169. Regarding the issue of his prescribing benzodiazepines to Patient C, respondent prescribed the benzodiazepines to her as a bridge, and referred her to a psychiatrist after her psychiatrist died to keep her out of the hospital. But SDFC's behavioral health services unit was understaffed, and patients waited three months for appointments. Respondent stated he was told to maintain them on medications until the SDFC behavioral health unit could see them.

170. With respect to prescribing naloxone for Patient C, respondent testified she had no interest in naloxone and her live-in boyfriend had his own issues; he would not have been a reliable provider of naloxone. In any case, Patient C was not concerned about overdosing and, respondent added, a possible overdose was not clinically indicated.

171. Regarding his care and treatment of Patient B, respondent noted she was on a very complex medley of medications and her pain was never well controlled. He

wanted to maintain her on these medications while he evaluated her case. Respondent tried to taper her medications as best as he could. Eventually, he ordered an extensive reevaluation and a new MRI to do this. Respondent said he was exploring every option and, as an example of his effort, referred her to an acupuncturist. As with the other patients, respondent said he reviewed CURES and conducted a pill count.

172. Respondent stated he did not feel UDT was clinically needed for Patient B based on his interactions with her.

173. Concerning naloxone for Patient B, respondent testified no person was living with her to administer the drug in case she accidentally overdosed. He thus did not prescribe the drug.

174. Regarding his care and treatment of Patient A, respondent stressed he saw him only a few times. Patient A, it seemed to respondent, had a legitimate reason for taking pain medications, and his pain was somewhat controlled. He noted he confirmed Patient A had a scar on his neck from surgery. Respondent remembered Patient A because he was taking methadone and he brought his bottles with him when respondent first saw him. Respondent also confirmed the medications Patient A was taking through CURES.

175. With respect to his prescription of methadone, respondent said he was concerned about this drug and the other medications Patient A was taking, but he did not want to change them until he had Patient A's records. With regard to his prescription of Ritalin, respondent maintained Patient A on this medication while he waited for an appointment with SDFC's behavioral health unit. He was told Patient A was stable and because he was stable, maintained him on Ritalin until his appointment with behavioral health.

176. Respondent discussed at length Patient A's fall outside a bar where he was rendered unconscious. He insisted the incident was not alcohol related and Patient A had a mechanical fall.[13] Respondent pointed out that Patient A was not found to be intoxicated at the hospital, and alcohol intoxication was also not included in the differential. Respondent also dismissed the four-point alcohol abuse audit score as a marginal score. To respondent, it did not indicate Patient A had a history of alcohol abuse.

177. Respondent, in addition, discussed at length the timeline regarding the administration of the EKG to Patient A on November 8, 2017, after the pharmacy contacted the clinic to report that Patient A appeared to be intoxicated and smelled of alcohol and Patient A reported he felt dizzy. Respondent emphasized he voided his prescriptions soon after the pharmacy reported Patient A's behavior to the clinic.

178. Respondent submitted certificates stating that he successfully completed on July 17, 2020, opioid prescribing practices courses and pain management courses.

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[13] Respondent's defense that Patient A was not found to be intoxicated at the hospital misses this larger point and the concern Dr. Huang raised in his analysis. The record indicates that Patient A was using alcohol while taking high dose opioids and methadone, and he may have had an alcohol abuse problem. It is worth repeating that Patient A acknowledged he used alcohol and had an audit score of "4" indicating possible alcohol abuse, he fell outside a bar where alcohol is served, and he was noted at the hospital to not be "particularly intoxicated" suggesting he was intoxicated to an extent. On November 8, 2017, a pharmacy staff person reported to respondent that Patient A smelled of alcohol when picking up his prescribed narcotics.

Testimony of Other Witnesses

179. Respondent called Jonathan Baker, M.D. and Cynthia Perez, R.N. as witnesses.

180. Dr. Baker is Medical Director of San Diego American Indian Health Center and was Medical Director at SDFC. Dr. Baker is board certified in family medicine and has been practicing medicine since 1997.

181. Dr. Baker described the patient population at SDFC as a population that is very difficult to care for. He said there are a lot of patients with mental health problems including schizophrenia and they have little education. It is difficult, he added, to communicate with these patients.

182. During the opioid crisis, SDFC inherited a large number of patients on opioids. Respondent, Dr. Baker noted, was reassigned the "lion's share" of these patients after Dr. Risser was no longer able to see them.

183. Dr. Baker felt it prudent to try to address the issue considering the reports in the literature of opioids causing respiratory depression. In this context, SDFC advised all clinic patients on September 6, 2017, that, "In response to the opiate and addictive medication epidemic," SDFC's clinics would be "limiting the prescribing of addictive medications." Dr. Baker was also involved in the creation of respondent's controlled medication policy change where he advised his patients after July 9, 2018, he would no longer prescribe addictive medications. This advisement, he noted, was sent to all patients and posted at SDFC's clinics.

184. Dr. Baker discussed the behavioral health treatment at SDFC and its availability for patients. He said there was a backlog of referrals to behavioral health

and to psychiatrists. Patients commonly waited for long periods of time to see psychiatrists who would accept the rates of clinic patients. Dr. Baker said the wait time for appointments was between three to six months.

185. Dr. Baker, in addition, commented that there were few addiction specialists and pain management specialists available to clinic patients. Pain management specialists would not see patients unless there were sufficient records to continue pain therapy. SDFC had difficulty obtaining patient records due to its limited budget. SDFC family care doctors were not in charge of getting records.

186. Cynthia Perez, R.N, is Director of Nursing at SDFC's Linda Vista Clinic where respondent worked. She has been at SDFC since June 2016. She worked with respondent at the same clinic building between 2016 and 2018.

187. Ms. Perez is familiar with respondent's custom and practices when he worked at the clinic. She testified that as a policy, CURES had to be run for an appointment and she ran CURES reports routinely every three months just to be on the safe side. CURES reports were run through respondent's CURES account and the reports printed and placed on respondent's desk for his review. She also saved the searches. She said she always printed CURES reports for respondent when she was working. In addition, Ms. Perez ran CURES reports for patients requesting refills, even if respondent was not in the office. She ran these reports to see if the patient was obtaining narcotics from other doctors. If there were discrepancies, she would let respondent know. Ms. Perez testified she was not familiar with respondent's pill counting policy.

188. After the CURES reports were printed, the reports were given to medical assistants to scan into patient records, but Ms. Perez was not sure the reports would in fact be scanned into the patient records.

The Parties' Arguments

189. Complainant in closing argued that clear and convincing evidence has established respondent committed gross negligence and repeated negligent acts in his care and treatment of the four patients and discipline should be imposed against his license consistent with the board's disciplinary guidelines. Complainant stressed that Dr. Huang's opinions should be found fully persuasive. His testimony was consistent with the standards of care articulated by the board in its 2014 guidelines and by the CDC in its 2016 guidelines. Complainant detailed the evidence of record in his closing comments citing Dr. Huang's opinions regarding each of the four patients and the evidence of record.

190. Complainant asked if causes for discipline are found, consistent with the board's disciplinary guidelines, respondent's license should be placed on five years' probation with terms and conditions that include an education course, prescribing and medical record keeping course, a practice monitor, and standard terms and conditions. Complainant stated that notification under Business and Professions Code section 2881 does not apply. Complainant also asked for costs.

191. Respondent in his closing statements, and a hearing brief he submitted,[14] emphasized that respondent's care and treatment of the four patients must be viewed

[14] Respondent's hearing brief has been marked as Exhibit Q and made part of the hearing record.

as what a reasonable physician would do under the same or similar circumstances. In support of his argument regarding the "similar circumstances" standard of care respondent cited *Avivi v. Centro Medico Urgente Medical Center* (2008) 159 Cal.App.4th 463, 470-471.)

Respondent detailed the treatment he provided to each of the patients and the challenges they posed with the limited resources available at SDFC. Respondent argued that respondent should not be a victim of a retroactive view of the standard of care per Dr. Huang's evaluation. But regardless, respondent met the standard of care in all respects based on the opinions offered by Drs. Stenzel and Badre. He termed the allegation of gross negligence relating to Patient A "way over the top," considering the limited time he treated Patient A and that he was a legacy patient.

In summary, respondent stated he did not, in a cavalier manner, write prescriptions without treating these patients and without a plan. He tried to taper the controlled medications they were taking; he finally concluded in August 2018 he could no longer prescribe addictive medications to patients on addictive medications. He did the best he could, and he is not a danger to the public. Respondent added that he may be rightly criticized for his documentation lapses. At most, respondent stated, he should be subject to a reprimand.

Evaluation of Expert Testimony and Evidence

192. The decision in this matter requires resolving the conflict in the testimony of the experts. In this regard, consideration has been given to their qualifications and credibility, the factual bases of their opinions, the reasons for their opinions, and any biases that could color their opinions and review of the evidence. California courts have repeatedly underscored that an expert's opinion is only as good as the facts and

reasons upon which that opinion is based. (*Kennemur v. State of California* (1982) 133 Cal.App.3d 907, 924.)

After giving due consideration to these factors, Dr. Huang's opinions regarding respondent's care and treatment of the four patients at issue in this matter are found more persuasive than Dr. Stenzel's opinions. The weight given to Dr. Badre's opinions is discussed below.

193. The conclusion to give more weight to Dr. Huang's opinions than Dr. Stenzel's is reached primarily for this reason: While Drs. Stenzel and Huang both have impressive credentials and experience, on balance, Dr. Huang is found to be more qualified as an expert in the area of pain management therapy considering his long standing work at the VA and Loma Linda, and his extensive experience teaching residents and interns since 2002 in both the inpatient and outpatient settings. Dr. Huang also has extensive clinical experience treating patients through his work at the VA since 2000, and he has significant experience treating patients with opioids and other addictive medications in opioid pain management therapy. He has kept up on the literature regarding the applicable standards of care for management of opioid pain management and addictive medications patients. Dr. Huang articulated, in great detail, the applicable standards of care for the treatment of pain management patients. These standards of care are well-founded and based on the board's and CDC's guidelines and other sources.

Dr. Stenzel's experience is more limited. She has mostly worked in FQHCs as a physician and in leadership capacities. At these FQHCs she managed heavy caseloads of patients dependent on controlled medications. She also served on task forces related to address prescribing pain medications safely and efforts to get medication assisted treatment to communities. She last taught in 2003. In contrast to Dr. Huang's

detailed summary of the standards of care, Dr. Stenzel articulated a narrow standard of care that applies only to physicians who work at FQHCs with limited resources; her opinion in this regard is not accepted. It is found that the standards of care Dr. Huang cited in his testimony applied to respondent as a primary care physician who worked at SDFC, an FQHC, and respondent did not convincingly argue to the contrary. He testified that the standard of care should be the same to ensure equal care for all patients. The court decision respondent cites in his hearing brief, *Avivi, supra*, does not support respondent's similar circumstances argument. The court in *Avivi* found that geographical location may be a factor to be considered in making that determination, but, by itself, does not provide a practical basis for measuring similar circumstances. (*Avivi, supra*, 159 Cal. App. 4th 463, 469-470 [citations omitted].)

Dr. Stenzel's opinions regarding management of patients on high dose opioid and addictive medication therapy are found unpersuasive. Her opinion dismissing the use of UDTs to manage pain management patients conflicts with the board's and CDC's guidelines, which Dr. Huang testified, incorporated the standard of care for addictive pain management therapy. The CDC and the board have stressed the value and importance of UDTs in monitoring opioid pain management patients. (See CDC Guideline for Prescribing Opioids, p. 8, "risk mitigation strategies [include] urine drug testing," p. 14, "Potential benefits of PDMPs and urine drug testing include the ability to identify patients who might be at higher risk for opioid overdose or opioid use disorder, and help determine which patients will benefit from greater caution and increased monitoring or interventions when risk factors are present." (Exhibit 31, A7427 and A7433); Medical Board's Guidelines for Prescribing Controlled Substances for Pain, p. 10, "As a universal precaution undertaking urine drug testing [regarding patient evaluation and risk stratification]."(Exhibit 32, A7482.)). Dr. Stenzel's opinion regarding the use of naloxone is also not accepted. Dr. Huang's opinion that the

standard of care at the time respondent cared for the patients at issue in this matter applied is found persuasive.

194. Concerning Dr. Badre's testimony and his opinions, Dr. Badre testified as a dispassionate expert from his perspective in the field of forensic psychiatry. His testimony with respect to the appropriateness of the benzodiazepines, and Ambien, respondent prescribed to patients B and C is found persuasive.

FIRST CAUSE FOR DISCIPLINE

195. The first amended accusation identifies conduct where respondent is alleged to have committed gross negligence in his care and treatment of Patient A. With respect to Patient A, the first amended accusation alleges that respondent committed gross negligence for failing to manage Patient A's chronic opioid therapy, including a better initial assessment for opiate addiction risks, attempts to taper Patient A's opiate use, a prescription for naloxone, and the use of UDT and/or documentation of CURES reviews.

As a matter of finding Patient A engaged in gross, as opposed to simple, negligence Dr. Huang's testimony is not found persuasive regarding respondent's management of Patient A's opioid therapy. Dr. Huang did not clearly articulate why he reached the conclusion that respondent committed an extreme departure from the standard of care he identified except to note in his report that he reached the conclusion in "totality." He did not explain that he reached this conclusion because respondent committed simple departures from the standards of care or that he believed he so departed from the standard of care that there was no care at all. Based on this record it cannot be found that respondent's conduct as alleged in the first cause for discipline can be viewed as "the want of even scant care or an extreme

departure from the ordinary standard of care." (*Kearl v. Board of Medical Quality Assurance* (1986) 189 Cal.App.3rd 1040, 1052.) This cause for discipline is dismissed.

SECOND CAUSE OF DISCIPLINE

196. The first amended accusation alleges that respondent committed repeated negligence acts with respect to his care of the four patients at issue in this matter.

197. Regarding Patient A, the clear and convincing evidence established that respondent committed repeated negligent acts because he departed from the standards of care for treating high dose opioid patients when he failed to properly manage Patient A's chronic opioid therapy, when he did not utilize an ORT assessment to assess his addiction risk, he did not taper Patient A's opioid use, he did not prescribe naloxone to Patient A despite Patient A's very high dosage opioid use, and he did not use UDTs to monitor Patient A, who it is noted was reported to have said he was diverting medications prescribed to him. Respondent is not found to have departed from the standard of care with respect to using CURES, even if this was not documented in the patient's record. His testimony that he reviewed CURES reports is found credible.

Respondent is, further, found to have committed repeated negligent acts when he departed from the applicable standards of care when he did not obtain a baseline EKG for Patient A when respondent took on management of Patient A's methadone therapy and when he did not confirm Patient A's ADHD diagnosis or assess him for this condition. It is not found that respondent departed from the standard of care for failing to obtain Patient A's medical records. The evidence demonstrates that SDFC had difficulties obtaining patient medical records.

198. Regarding Patient B, the clear and convincing evidence established that respondent committed repeated negligent acts when he departed from the standards of care when he failed to perform an initial risk assessment of Patient B's addiction potential, when he failed to conduct UDTs and taper her medications, and when he did not prescribe naloxone to her. He further departed from the standard of care when he did not document his reasons for prescribing lorazepam to Patient B.

It is not found that departed from the standard of care when he concurrently prescribed benzodiazepines and Ambien to her. Dr. Badre's testimony in this regard is found persuasive.

199. Concerning Patient C, the clear and convincing evidence established that respondent departed from the applicable standards of care when he did not try to taper her opioid use sooner, when he did not conduct adequate periodic UDTs, and when he did not prescribe naloxone to Patient C. Dr. Stenzel's testimony that COPD is not one of the pulmonary conditions that would require the use of naloxone is not found persuasive. Patient C's medical records document that Patient C had a lung mass or lung scarring, and low oxygen saturation rates. She, further, had gunshot shrapnel her left chest and had undergone a partial lobectomy.

It is not found that respondent departed from the standard of care when he concurrently prescribed benzodiazepines to Patient C based on Dr. Badre's persuasive testimony.

200. Concerning Patient D, the clear and convincing evidence established that respondent committed repeated negligent acts when he departed from the applicable standards of care when he did not conduct more frequent UDTs, and when he did not prescribe naloxone to Patient D.

Costs of Enforcement

201. Complainant seeks recovery of enforcement costs in the total amount of $20,748.75 for work done between January 1, 2022, and September 26, 2022, pursuant to Business and Professions Code section 125.3.[15]

202. In support of the request for recovery of enforcement costs, the Deputy Attorney General who prosecuted the case signed an initial declaration dated September 6, 2022, and supplemental declaration on September 26, 2022, requesting $20,748.75 relating to the legal work performed in this matter. Attached to the declarations are two documents entitled "Master Time Activity by Professional Type." These documents identify the tasks performed, the dates legal services were provided, who provided the services, the time spent on each task, and the hourly rate for the Supervising Deputy Attorney General, Deputies Attorney General, and paralegal from January 31, 2022, through September 26, 2022, for the total prosecution costs.

203. California Code of Regulations, title 1, section 1042, subdivision (b), requires that this declaration must include "specific and sufficient facts to support findings regarding actual costs incurred and the reasonableness of the costs."

204. The declarations with the attachments identify the tasks performed and comply with the specificity requirements of section 1042, subdivision (b). The costs are found to be reasonable. Accordingly, the total reasonable costs of enforcement of this

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[15] The Attorney General billed for legal work performed after January 1, 2022. Prior to that date, complainant was unable to obtain costs of enforcement. Effective January 1, 2022, SB806 amended Business and Professions Code section 125.3 to allow the board to obtain costs.

matter are $20,748.75. Respondent did not present any evidence regarding his ability to pay costs.

LEGAL CONCLUSIONS

Purpose of Physician Discipline

1. The purpose of the Medical Practice Act (Chapter I, Division 2, of the Business and Professions Code) is to assure the high quality of medical practice; in other words, to keep unqualified and undesirable persons and those guilty of unprofessional conduct out of the medical profession. (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 574.)

The purpose of administrative discipline is not to punish, but to protect the public by eliminating those practitioners who are dishonest, immoral, disreputable or incompetent. (*Fahmy v. Medical Board of California* (1995) 38 Cal.App.4th 810, 817.)

Standard of Proof

2. Complainant bears the burden of proof of establishing that the charges in the first amended accusation are true.

The standard of proof in an administrative action seeking to suspend or revoke a physician's certificate is clear and convincing evidence. (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.) Clear and convincing evidence requires a finding of high probability, or evidence so clear as to leave no substantial doubt; sufficiently strong evidence to command the unhesitating assent of every reasonable mind. (*Katie V. v. Superior Court* (2005) 130 Cal.App.4th 586, 594.)

Applicable Statutes Regarding Causes to Impose Discipline

3. Section[16] 2227, subdivision (a), states:

> A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may in accordance with the provisions of this chapter:
>
> (1) Have his or her license revoked upon order of the board.
>
> (2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.
>
> (3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.
>
> (4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.

[16] References are to the Business and Professions Code unless otherwise stated.

(5) Have any other action taken in relation to the discipline as part of an order of probation, as the board or an administrative law judge may deem proper.

4. Section 2234 provides in part:

The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

[¶] . . . [¶]

(b) Gross negligence.

(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

Decisional Authority Regarding Standard of Care

5. The standard of care requires the exercise of a reasonable degree of skill, knowledge, and care that is ordinarily possessed and exercised by members of the medical profession under similar circumstances. The standard of care involving the acts of a physician must be established by expert testimony. (*Elcome v. Chin* (2003) 110 Cal.App.4th 310, 317.) It is often a function of custom and practice. (*Osborn v. Irwin Memorial Blood Bank* (1992) 5 Cal.App.4th 234, 280.)

Courts have defined gross negligence as "the want of even scant care or an extreme departure from the ordinary standard of care." (*Kearl*, supra, 189 Cal.App.3rd 1040, 1052.) Simple negligence is merely a departure from the standard of care.

Disposition Regarding Causes for Discipline

CAUSE DOES NOT EXIST UNDER THE FIRST CAUSE FOR DISCIPLINE TO IMPOSE DISCIPLINE AGAINST RESPONDENT'S LICENSE FOR CONDUCT CONSTITUTING GROSS NEGLIGENCE

6. Complainant did not prove by clear and convincing evidence that respondent committed gross negligence in violation of Section 2234, subdivision (b), with respect to respondent's treatment and care of Patient A based on the findings in this decision.

CAUSE EXISTS UNDER THE SECOND CAUSE FOR DISCIPLINE TO IMPOSE DISCIPLINE AGAINST RESPONDENT'S LICENSE FOR REPEATED NEGLIGENT ACTS

7. Complainant proved by clear and convincing evidence that respondent committed repeated negligent acts in violation of Section 2234, subdivision (c), with respect to respondent's treatment and care of the four patients at issue in this matter based on the findings in this decision.

The Board's Disciplinary Guidelines and Evaluation Regarding the Degree of Discipline

8. With causes for discipline having been found, the determination now must be made regarding the degree of discipline and the terms and conditions to

impose. As noted, the purpose of an administrative proceeding seeking the revocation or suspension of a professional license is not to punish the individual, the purpose is to protect the public from dishonest, immoral, disreputable or incompetent practitioners. (*Fahmy, supra*, 38 Cal.App.4th at p. 817.) Rehabilitation is a state of mind and the law looks with favor upon rewarding with the opportunity to serve one who has achieved "reformation and regeneration." (*Pacheco v. State Bar* (1987) 43 Cal.3d 1041, 1058.)

The board's Manual of Model Disciplinary Orders and Disciplinary Guidelines (12th Edition 2016) offers this guidance concerning the imposition of discipline:

> The Board expects that, absent mitigating or other appropriate circumstances such as early acceptance of responsibility, demonstrated willingness to undertake Board-ordered rehabilitation, the age of the case, and evidentiary problems, Administrative Law Judges hearing cases on behalf of the Board and proposed settlements submitted to the Board will follow the guidelines, including those imposing suspensions. Any proposed decision or settlement that departs from the disciplinary guidelines shall identify the departures and the facts supporting the departure.

9. For each of the violations established relating to respondent's care and treatment of Patients A, B, C, and D, the board's disciplinary guidelines provide that revocation is the maximum discipline and provide the following minimum recommended terms and conditions:

- For gross negligence and repeated negligent acts under Business and Professions Code section 2234, subdivisions (b) and (d), or failure to maintain adequate records under Business and Professions Code section 2266, revocation, stayed, and five years' probation, with conditions including an education course, prescribing practices course, medical record keeping course, professionalism program (ethics course), clinical competence assessment program, monitoring, solo practice prohibition, and prohibited practices. In cases charging repeated negligent acts with one patient, a public reprimand may, in appropriate circumstances, be ordered.

Disciplinary Considerations and Disposition Regarding the Degree of Discipline

10. As noted, the purpose of an administrative proceeding seeking the revocation or suspension of a professional license is not to punish the individual, the purpose is to protect the public from dishonest, immoral, disreputable or incompetent practitioners. (*Fahmy, supra*, 38 Cal.App.4th at p. 817.) Rehabilitation is a state of mind and the law looks with favor upon rewarding with the opportunity to serve one who has achieved "reformation and regeneration." (*Pacheco v. State Bar* (1987) 43 Cal.3d 1041, 1058.)

11. After considering the board's guidelines, evidence of mitigation, and the evidence of record as a whole, it is determined that respondent's license should be placed on problem for three years with terms and conditions to ensure public protection.

This determination is made for these reasons: The nature and extent of respondent's conduct exposed the four patients to harm. Respondent did not adequately monitor the patients as a matter of their opioid and addictive pain medicine therapy. All of the patients were dependent on high dose opioids, and other addictive medications, and all of them had serious medical and psychiatric issues. Once he was assigned these patients respondent took a passive approach to monitoring them *and* prescribing addictive medications to them and, as found, his monitoring was inadequate. He did not use tools available to him to ensure their health and safety, including UDTs and naloxone. He should have more aggressively tapered their addictive medications or prescribed to them alternative or less dangerous medications.

Respondent, in addition, prescribed Patients A and B addictive medications without adequate reasons to do so. He prescribed to Patient A Ritalin based on his conclusion Patient A had ADHD without confirming this diagnosis or evaluating whether he in fact had ADHD. Respondent also prescribed lorazepam to Patient B without evaluating her to justify this prescription.

12. With this stated, the following mitigating factors in respondent's favor have been considered in assessing the degree of discipline to impose: respondent was in a difficult position in terms of his ability to care and treat the patients. They were legacy patients whose prior physicians had prescribed them high dose opioids and other addictive medications, and they were dependent on these medications. Respondent maintained them on the medications for their well-being to avoid withdrawal. Patient C was hospitalized when she stopped taking the benzodiazepines. Patient B was struggling with mental health problems due to being a victim of domestic violence and it would have been "very dangerous" to stop prescribing

benzodiazepines to her, per Dr. Badre. Several of the patients resisted efforts he made to taper their medications. In addition, respondent could not easily refer the patients to pain management or to an addiction medicine specialist. Pain management physicians were reluctant to take on the care of these patients, and it was hard to find specialists for these patients in addiction medicine. The wait time for appointments to see psychiatrists for SDFC patients was between three to six months.

Respondent, further, conscientiously tried to treat these patients and was attentive to them and their needs. He referred the patients to numerous specialists. In the end, respondent decided to stop prescribing opioid and addictive medications entirely and advised his patients he would refer them to pain management and/or to psychiatry.

After giving due consideration to these factors, due to the nature and extent of respondent's conduct, and that the conduct involved four patients, a disposition of a term of probation with terms and conditions to ensure public protection is nonetheless warranted. The mitigating factors, however, do warrant departures from the board's guidelines in these respects: It is not necessary for public protection that respondent's license be placed on probation for five years. A three-year period of probation is adequate. In addition, public protection does not require that respondent attend a clinical competency assessment program, be subject to a practice monitor, be prohibited from the solo practice of medicine, or be prohibited from supervising physician assistants and advanced practice nurses.

Costs of Enforcement

13. Under Business and Professions Code section 125.3, complainant may request that an administrative law judge "direct a licentiate found to have committed a

violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case." "A certified copy of the actual costs, or a good faith estimate of costs where actual costs are not available, signed by the entity bringing the proceeding or its designated representative shall be prima facie evidence of reasonable costs of investigation and prosecution of the case." (Bus. & Prof. Code, § 125.3, subd. (c).)

14. Another consideration in determining costs is *Zuckerman v. Board of Chiropractic Examiners* (2002) 29 Cal.4th 32. In *Zuckerman*, the California Supreme Court decided, in part, that in order to determine whether the reasonable costs of investigation and enforcement should be awarded or reduced, the administrative law judge must decide: (a) whether the licensee has been successful at hearing in getting charges dismissed or reduced; (b) the licensee's subjective good faith belief in the merits of his or her position; (c) whether the licensee has raised a colorable challenge to the proposed discipline; (d) the financial ability of the licensee to pay; and (e) whether the scope of the investigation was appropriate to the alleged misconduct. The scope of the investigation was appropriate to the allegations. The charges were sustained, and respondent provided no evidence regarding his ability to pay the costs.

15. After consideration of the factors under *Zuckerman, supra,* a substantial reduction in the amount of reasonable costs of $20,748.75 is required because respondent successfully challenged the gross negligence allegation and several allegations of simple negligence. Accordingly reasonable costs are assessed at $13,000.

ORDER

Certificate No. C 54416 issued to respondent Jeffrey A. Cullen, M.D., is revoked. However, revocation is stayed, and respondent is placed on probation for three years on the following terms and conditions:

1. Education Course

Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 40 hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified. The educational program(s) or course(s) shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of CME of which 40 hours were in satisfaction of this condition.

2. Prescribing Practices Course

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a course in prescribing practices approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after respondent's initial enrollment.

Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The prescribing practices course shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A prescribing practices course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

3. Medical Record Keeping Course

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a course in medical record keeping approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The medical record keeping course shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A medical record keeping course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

4. Notification

Within seven (7) days of the effective date of this Decision, the respondent shall provide a true copy of this Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to respondent, at any other facility where respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

5. Obey All Laws

Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

6. Quarterly Declarations

Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation.

Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

7. General Probation Requirements

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit.

Address Changes

Respondent shall, at all times, keep the Board informed of respondent's business and residence addresses, email address (if available), and telephone number. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021(b).

Place of Practice

Respondent shall not engage in the practice of medicine in respondent's or patient's place of residence, unless the patient resides in a skilled nursing facility or other similar licensed facility.

License Renewal

Respondent shall maintain a current and renewed California physician's and surgeon's license.

Travel or Residence Outside California

Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) calendar days.

In the event respondent should leave the State of California to reside or to practice respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return.

8. Interview with the Board or its Designee

Respondent shall be available in person upon request for interviews either at respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

9. Non-practice While on Probation

Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of respondent's return to practice. Non-practice is defined as any period of time respondent is not practicing medicine as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. If respondent resides in California and is considered to be in non-practice, respondent shall comply with all terms and conditions of probation. All time spent in an intensive training program which has been approved by the Board or its designee shall not be

considered non-practice and does not relieve respondent from complying with all the terms and conditions of probation. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

In the event respondent's period of non-practice while on probation exceeds 18 calendar months, respondent shall successfully complete the Federation of State Medical Board's Special Purpose Examination, or, at the Board's discretion, a clinical competence assessment program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

Respondent's period of non-practice while on probation shall not exceed two (2) years.

Periods of non-practice will not apply to the reduction of the probationary term.

Periods of non-practice for a respondent residing outside of California, will relieve respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; General Probation Requirements; and Quarterly Declarations.

10. Completion of Probation

Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation.

Upon successful completion of probation, respondent's certificate shall be fully restored.

11. Violation of Probation

Failure to fully comply with any term or condition of probation is a violation of probation. If respondent violates probation in any respect, the Board, after giving respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

12. License Surrender

Following the effective date of this Decision, if respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, respondent may request to surrender his or her license. The Board reserves the right to evaluate respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, respondent shall within 15 calendar days deliver respondent's wallet and wall certificate to the Board or its designee and respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

13. Probation Monitoring Costs

Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year.

14. Probation Monitoring and Enforcement Costs

Respondent shall pay the costs associated with the enforcement of this matter in the amount of $13,000. Respondent may negotiate a payment plan with the Board. In addition, respondent shall pay probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year.

DATE: October 31, 2022

Abraham M. Levy (Oct 31, 2022 16:03 PDT)

ABRAHAM M. LEVY
Administrative Law Judge
Office of Administrative Hearings

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Attorneys for Complainant

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Amended Accusation Against: **JEFFREY A. CULLEN, M.D.** **733 Kline St., Unit 206** **La Jolla, CA 92037-4306** **Physician's and Surgeon's Certificate No. C 54416,** Respondent.	Case No. 800-2018-049427 OAH No. 2021120060 **FIRST AMENDED ACCUSATION**

PARTIES

1. William Prasifka (Complainant) brings this First Amended Accusation solely in his official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about November 5, 2010, the Medical Board issued Physician's and Surgeon's Certificate No. C 54416 to Jeffrey A. Cullen, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on November 30, 2022, unless renewed.

JURISDICTION

3. This First Amended Accusation, which supersedes the Accusation filed on September 30, 2021, is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Section 2227 of the Code states, in pertinent part:

> (a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:
>
> (1) Have his or her license revoked upon order of the board.
>
> (2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.
>
> (3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.
>
> (4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.
>
> (5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.
>
> ...

5. Section 2234 of the Code, states, in pertinent part:

> The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:
>
> ...
>
> (b) Gross negligence.
>
> (c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.
>
> (1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.
>
> (2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the

licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

...

COST RECOVERY

6. Section 125.3 of the Code states:

(a) Except as otherwise provided by law, in any order issued in resolution of a disciplinary proceeding before any board within the department or before the Osteopathic Medical Board upon request of the entity bringing the proceeding, the administrative law judge may direct a licensee found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

(b) In the case of a disciplined licentiate that is a corporation or a partnership, the order may be made against the licensed corporate entity or licensed partnership.

(c) A certified copy of the actual costs, or a good faith estimate of costs where actual costs are not available, signed by the entity bringing the proceeding or its designated representative shall be prima facie evidence of reasonable costs of investigation and prosecution of the case. The costs shall include the amount of investigative and enforcement costs up to the date of the hearing, including, but not limited to, charges imposed by the Attorney General.

(d) The administrative law judge shall make a proposed finding of the amount of reasonable costs of investigation and prosecution of the case when requested pursuant to subdivision (a). The finding of the administrative law judge with regard to costs shall not be reviewable by the board to increase the cost award. The board may reduce or eliminate the cost award, or remand to the administrative law judge if the proposed decision fails to make a finding on costs requested pursuant to subdivision (a).

(e) If an order for recovery of costs is made and timely payment is not made as directed in the board's decision, the board may enforce the order for repayment in any appropriate court. This right of enforcement shall be in addition to any other rights the board may have as to any licensee to pay costs.

(f) In any action for recovery of costs, proof of the board's decision shall be conclusive proof of the validity of the order of payment and the terms for payment.

(g)(1) Except as provided in paragraph (2), the board shall not renew or reinstate the license of any licensee who has failed to pay all of the costs ordered under this section.

(2) Notwithstanding paragraph (1), the board may, in its discretion, conditionally renew or reinstate for a maximum of one year the license of any licensee who demonstrates financial hardship and who enters into a formal agreement with the board to reimburse the board within that one-year period for the unpaid costs.

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(h) All costs recovered under this section shall be considered a reimbursement for costs incurred and shall be deposited in the fund of the board recovering the costs to be available upon appropriation by the Legislature.

(i) Nothing in this section shall preclude a board from including the recovery of the costs of investigation and enforcement of a case in any stipulated settlement.

(j) This section does not apply to any board if a specific statutory provision in that board's licensing act provides for recovery of costs in an administrative disciplinary proceeding.

FIRST CAUSE FOR DISCIPLINE
(Gross Negligence)

7. Respondent has subjected his Physician's and Surgeon's Certificate No. C 54416 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (b), of the Code, in that he committed gross negligence in the care and treatment of Patient A,[1] as more particularly alleged hereafter:

Patient A

8. On or about April 5, 2017, Patient A, then a 51-year-old man, presented to Respondent at San Diego Family Care for an initial visit. Patient A complained of chronic neck and back pain, and had neck surgery in 2013. Patient A was requesting refills for his current medications which included methadone,[2] methylphenidate,[3] and oxycodone.[4] Respondent's assessments included cervicalgia and back pain. Respondent's plan was to obtain and review Patient A's prior medical records and refill his prescriptions. He gave Patient A a referral to an orthopedic surgeon for decreased strength and mobility in his hand.

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[1] Names of patients have been omitted to protect their privacy.

[2] Methadone is an opiate and a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (c).

[3] Methylphenidate is a stimulant and a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (d). It is commonly used to treat Attention Deficit/Hyperactivity Disorder (ADHD).

[4] Oxycodone, brand name OxyContin, is an opiate and a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b).

9. According to Patient A's CURES[5] report, on or about April 5, 2017, Patient A filled prescriptions written by Respondent for the following: (1) 270 tablets of 10 mg methadone; (2) 120 tablets of 10 mg methylphenidate; and (3) 120 tablets of 30 mg oxycodone.

10. From on or about May 2, 2017 through June 16, 2017, Patient A returned to the clinic and saw Respondent approximately three times. Respondent first noted Patient A's ADHD diagnosis by documenting that Patient A's symptoms were controlled on or about June 2, 2017. Respondent never assessed Patient A's ADHD diagnosis, nor did he ever obtain Patient A's prior medical records.

11. On or about May 2, 2017, Patient A filled prescriptions written by Respondent for the following: (1) 270 tablets of 10 mg methadone; (2) 120 tablets of 10 mg methylphenidate; and (3) 180 tablets of 30 mg oxycodone. Respondent failed to document why he increased Patient A's oxycodone dose.

12. On or about June 16, 2017, Patient A filled prescriptions written by Respondent for the following: (1) 270 tablets of 10 mg methadone; (2) 120 tablets of 10 mg methylphenidate; and (3) 120 tablets of 30 mg oxycodone.

13. On or about July 10, 2017, Patient A called Respondent's office to request refills. Patient A's refill request was rejected.

14. On or about July 10, 2017, Patient A went to the emergency room. According to the hospital records, Patient A had been drinking at a bar when he tripped and/or had a syncopal episode. Patient A had been knocked unconscious for several minutes and had a head laceration. The hospital records documented that Patient A abused alcohol. A copy of these hospital records were sent to Respondent's office and retained in Patient A's medical records.

15. On or about July 14, 2017, Patient A returned to the clinic and saw Respondent. Respondent noted that Patient A had a forehead laceration and stitches. He gave Patient A refills for his medications.

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[5] The Controlled Substance Utilization Review and Evaluation System (CURES) is a database of Schedule II, III, and IV controlled substance prescriptions dispensed in California serving the public health, regulatory oversight agencies, and law enforcement.

16. On or about the same day, Patient A filled the following prescriptions written by Respondent: (1) 270 tablets of 10 mg methadone; (2) 120 tablets of 10 mg methylphenidate; and (3) 180 tablets of 30 mg oxycodone. Again, Respondent failed to document why he increased Patient A's oxycodone dose.

17. On or about August 14, 2017, Patient A returned to the clinic and saw Respondent. Respondent removed Patient A's sutures and gave him refills for his medications. At this visit, Patient A signed a controlled medication agreement which stated that Patient A agreed to take controlled medications exactly as prescribed and that Patient A would not sell or trade his controlled medications.

18. On or about the same day, Patient A filled the following prescriptions written by Respondent: (1) 270 tablets of 10 mg methadone; (2) 120 tablets of 10 mg methylphenidate; and (3) 180 tablets of 30 mg oxycodone.

19. On or about September 6, 2017, Respondent's clinic sent Patient A a letter which stated that the clinic would be limiting the prescribing of addictive medications.

20. On or about September 13, 2017, Patient A returned to the clinic and saw Respondent. Patient A continued to complain of pain. Respondent refilled Patient A's medications.

21. On or about the same day, Patient A filled the following prescriptions written by Respondent: (1) 270 tablets of 10 mg methadone; (2) 120 tablets of 10 mg methylphenidate; and (3) 180 tablets of 30 mg oxycodone.

22. On or about October 11, 2017, Patient A returned to the clinic and saw Respondent. Patient A reported that he was hurting badly that day. Respondent refilled Patient A's medications and provided a referral to a pain management specialist.

23. On or about November 8, 2017, Patient A returned to the clinic and saw Respondent. Patient A said he was feeling woozy and dizzy. Respondent ordered lab tests and refilled Patient A's medications.

24. On or about the same day, Respondent's office received a phone call from a pharmacy. Patient A had been in the pharmacy that morning and appeared to be intoxicated and

was disoriented. He fell asleep at the pharmacy and admitted to the workers that he had sold his medications to have money to buy other medications. Respondent voided all of Patient A's prescriptions.

25. On or about November 13, 2017, Respondent's office sent Patient A a letter notifying Patient A that he was terminated as a patient.

26. Respondent committed gross negligence in his care and treatment of Patient A for, cont. failing to properly manage Patient A's chronic opioid therapy, which should have included a better initial assessment for opiate addiction risks, attempts to taper Patient A's opiate use, a prescription for naloxone,[6] and the use of urine drug screens and/or documentation of CURES reviews.

SECOND CAUSE FOR DISCIPLINE
(Repeated Negligent Acts)

27. Respondent has further subjected his Physician's and Surgeon's Certificate No. C 54416 to disciplinary action under sections 2227 and 2234, as defined by section 2334, subdivision (c), in that he committed repeated negligent acts in the care and treatment of Patients A, B, C, and D, as more particularly alleged hereafter:

Patient A

28. Paragraphs 8 through 26, above, are hereby incorporated by reference and re-alleged as if fully set forth herein.

29. Respondent committed repeated negligent acts in his care and treatment of Patient A which includes, but is not limited to, the following:

a. Respondent failed to properly evaluate Patient A's chronic pain which would include more attempts to obtain prior treatment records to justify continued drug therapy;

b. Respondent failed to order or obtain a baseline EKG at the start of Patient A's methadone therapy to minimize the risks of cardiac arrhythmias; and

c. Respondent failed to properly confirm Patient A's ADHD diagnosis to justify his continued Adderall use.

[6] Naloxone, brand name Narcan, is used to treat narcotic overdose.

Patient B

30. Patient B had been an established patient at San Diego Family Care since at least 2013.[7] On or about November 30, 2017, Patient B, then a 42-year-old female, returned to the clinic and saw Respondent. She complained of back pain and reported that a pain management specialist refused to see her because of insurance issues. Respondent refilled Patient B's medications which included Ambien,[8] lorazepam,[9] Soma,[10] gabapentin,[11] Prozac,[12] oxycodone and OxyContin.

31. According to Patient B's CURES report, on or about November 30, 2017, Patient B filled prescriptions written by Respondent for 42 tablets of 30 mg oxycodone and 10 tablets of 30 mg OxyContin. On or about December 5, 2017, Patient B filled a prescription written by Respondent for 120 tablets of 350 mg carisoprodol.

32. On or about December 5, 2017, a pharmacist called Respondent's clinic about filling Patient B's prescriptions. The pharmacist stated that he or she was not comfortable dispensing lorazepam, Ambien, oxycodone, and Soma to Patient B, and that Patient B had received controlled medications from three different providers in the same month. Respondent documented that he received the message.

33. On or about December 6, 2017, Patient B returned to the clinic and saw J.B., M.D. J.B., M.D., recommended that Patient B taper down her controlled medications and go to the hospital if she started experiencing withdrawal symptoms.

34. On or about December 7, 2017, Patient B returned to the clinic and saw Respondent. Patient B signed a controlled medication agreement, which stated, in part, that Patient B would only obtain her controlled substance medications from one provider and one pharmacy. On or

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[7] Conduct occurring more than seven (7) years from the filing date of this Accusation or more than three (3) years from notification to the Board is for informational purposes only and is not alleged as a basis for disciplinary action.

[8] Ambien, brand name for zolpidem tartrate, is a sedative hypnotic and a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d).

[9] Lorazepam is a benzodiazepine and a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d).

[10] Soma, brand name for carisoprodol, is a muscle relaxant.

[11] Gabapentin is an anti-convulsant and nerve pain medication.

[12] Prozac, brand name for fluoxetine, is an anti-depressant.

about the same day, she filled a prescription written by Respondent for 120 tablets of 30 mg oxycodone.

35. According to CURES, on or about December 21, 2017, Patient B filled a prescription written by M.K., M.D., for 84 tablets of 30 mg oxycodone.

36. On or about January 3, 2018, Patient B returned to the clinic and saw Respondent. She reported that she had recently gone to a rheumatologist and that her chronic neck and back pain continued. Respondent refilled Patient B's prescriptions.

37. On or about January 3, 2018, Patient B filled prescriptions written by Respondent for 30 tablets of 10 mg Ambien and 90 tablets of 1 mg lorazepam. On or about January 4, 2018, Patient B filled a prescription written by Respondent for 42 tablets of 30 mg oxycodone (a seven-day supply). On or about January 11, 2018, Patient B filled one prescription written by Respondent for 60 tablets of 30 mg OxyContin, and one prescription written by another treatment provider, R.A., P.A., for 230 tablets of 30 mg oxycodone.

38. Respondent's records include a progress note dated January 12, 2018 from R.A., P.A. R.A., P.A.'s supervising physician was M.K., M.D. R.A., P.A.'s plan was to continue Patient B on gabapentin and to refill her oxycodone prescription for two weeks.

39. Respondent's records include another progress note dated January 25, 2018 from R.A., P.A. R.A., P.A., was to give Patient B a referral to a pain management specialist. Patient B requested a three-week supply of oxycodone until she could see the specialist, and reported that the gabapentin was providing no pain relief. On or about the same day, Patient B filled a prescription written by M.K., M.D., for 126 tablets of 30 mg oxycodone.

40. On or about January 30, 2018, Patient B returned to the clinic and saw Respondent. Respondent refilled Patient B's prescriptions.

41. On or about January 31, 2018, Patient B filled a prescription written by Respondent for 120 tablets of 350 mg carisoprodol. On or about February 2, 2018, despite getting a 30-day refill on or about January 25, 2018, Patient B filled a prescription written by Respondent for 120 tablets of 30 mg oxycodone. On or about February 15, 2018, Patient B filled a prescription written by Respondent for 60 tablets of 30 mg OxyContin.

42. On or about February 23, 2018, Patient B returned to the clinic and saw Respondent. She continued to complain of neck and back pain and said that her medications were effective. Respondent's plan was to continue Patient B's medications. On or about the same day, a pharmacy called Respondent's office and reported that Patient B was requesting an early refill for oxycodone. Respondent's office denied this request.

43. On or about February 23, 2018, Patient B filled prescriptions written by Respondent for 30 tablets of 10 mg Ambien and 30 tablets of 1 mg lorazepam. On or about February 25, 2018, Patient B filled a prescription written by Respondent for 180 tablets of 30 mg oxycodone. On or about March 1, 2018, Patient B filled a prescription written by Respondent for 120 tablets of 350 mg carisoprodol. Respondent failed to document why Patient B's oxycodone dose was increased.

44. On or about March 16, 2018, Patient B returned to the clinic and saw Respondent. In addition to her chronic neck and back pain, Patient B complained of increased thoracic pain. Respondent refilled Patient B's medications.

45. On or about March 17, 2018, Patient B filled prescriptions written by Respondent for 90 tablets of 350 carisoprodol and 60 tablets of 30 mg OxyContin. On or about March 18, 2018, Patient B filled prescriptions written by Respondent for 30 tablets of 10 mg Ambien and 30 tablets of 1 mg lorazepam. On or about March 19, 2018, Patient B filled a prescription written by Respondent for 180 tablets of 30 mg oxycodone.

46. According to CURES, on or about March 30, 2018, Patient B filled a prescription written by a new treatment provider, N.B., for 60 tablets of 15 mg oxycodone.

47. On or about April 9, 2018, Patient B filled a prescription written by Respondent for 30 tablets of 350 mg carisoprodol and 30 tablets of 1 mg lorazepam.

48. On or about April 11, 2018, Patient B returned to the clinic and saw Respondent. Patient B complained of pelvic pain and had a rapid heart rate. Respondent refilled Patient B's medications. On or about the same day, Patient B filled prescriptions written by Respondent for 120 tablets of 350 mg carisoprodol and 180 tablets of 30 mg oxycodone. On or about April 16, 2018, Patient B filled a prescription written by Respondent for 60 tablets of 30 mg OxyContin.

49. On or about May 3, 2018, Patient B returned to the clinic and saw Respondent. Respondent noted that little progress had been made with pain management and rheumatology consultations, and that Patient B was going to see a neurosurgeon. Respondent ordered lumbar and cervical spine MRIs.

50. On or about May 4, 2018, Patient B filled prescriptions written by Respondent for 30 tablets of 10 mg Ambien and 90 tablets of 350 mg carisoprodol. On or about May 6, 2018, Patient B filled a prescription written by Respondent for 90 tablets of 30 mg oxycodone. On or about May 16, 2018, Patient B filled a prescription written by Respondent for 60 tablets of 30 mg OxyContin. On or about May 27, 2018, Patient B filled a prescription written by Respondent for 30 tablets of 350 mg carisoprodol.

51. On or about May 30, 2018, Patient B went to a pain management specialist. She wanted a second opinion regarding surgery and requested to be weaned off opiates. Patient B was told to talk to Respondent to taper her medications, as he was the treatment provider who was prescribing them.

52. On or about June 1, 2018, Patient B returned to the clinic and saw Respondent. Respondent's plan was to wean Patient B's narcotic therapy. He gave Patient B refills for 60 tablets of 30 mg OxyContin and 120 tablets of 30 mg oxycodone, with instructions for Patient B to take half a tablet of oxycodone every six hours as needed.

53. On or about June 8, 2018, Patient B filled the prescription written by Respondent for 120 tablets of 30 mg oxycodone. On or about June 15, 2018, Patient B filled the prescription written by Respondent for 60 tablets of 30 mg OxyContin.

54. On or about June 26, 2018, Patient B called Respondent's office and requested prescription refills. Patient B was reminded that the plan was to taper down her medications, and that she needed to make an appointment with her primary care physician if she needed refills.

55. On or about June 28, 2018, Patient B returned to the clinic and saw Respondent. Patient B needed medication refills, including a refill for lorazepam. Respondent refilled her medications and put Patient B back on 180 mg of oxycodone per day or 180 tablets of 30 mg oxycodone per month.

56. On or about June 28, 2018, Patient B filled a prescription written by Respondent for 30 tablets of 1 mg lorazepam. On or about June 29, 2018, Patient B filled another prescription written by Respondent for 180 tablets of 30 mg oxycodone. On or about July 23, 2018, Patient B filled a prescription written by Respondent for 30 tablets of 10 mg Ambien.

57. On or about July 26, 2018, Patient B returned to the clinic and saw Respondent. Even though Respondent documented that Patient B was to take up to four tablets of 30 mg oxycodone per day as needed, Respondent gave Patient B a refill prescription for 180 tablets of 30 mg oxycodone, which would allow Patient B to take up to six tablets.

58. On or about July 26, 2018, Patient B filled prescriptions written by Respondent for 120 tablets of 350 mg carisoprodol and 180 tablets of 30 mg oxycodone. On or about July 30, 2018, Patient B filled a prescription written by Respondent for 30 tablets of 1 mg lorazepam.

59. On or about August 8, 2018, Respondent's office received a call from Patient B's health plan. They reported that CURES showed that Patient B was picking up her oxycodone and OxyContin prescriptions at eight different pharmacies.

60. On or about August 8, 2018, Patient B failed to appear for a scheduled appointment with Respondent. Patient B was notified by letter that she needed to make an appointment to receive any refills on her medications.

61. On or about August 15, 2018, Patient B returned to the clinic and saw Respondent. Patient B reported little improvement in her pain and said she was planning on entering a 60-day program for domestic violence victims.

62. Respondent committed repeated negligent acts in his care and treatment of Patient B which includes, but is not limited to, the following:

a. Respondent failed to properly monitor Patient B's chronic opioid therapy which would include an initial risk assessment for addiction potential, periodic urine drug screens, and/or an immediate attempt to taper her medications;

b. Respondent failed to document the indication for Patient B's long-term use of lorazepam;

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c. Respondent concurrently prescribed benzodiazepines and opioids to Patient B, putting her at increased risk for accidental death from overdose, and failed to prescribe naloxone to mitigate the risks; and

d. Respondent failed to try safer and less addictive alternatives to treat Patient B's insomnia.

Patient C

63. Patient C had been an established patient at San Diego Family Care since at least 2010. On or about June 17, 2016, Patient C, then a 55-year-old female, returned to the clinic and saw Respondent. Patient C's pertinent medical history included a leg amputation and hemipelvectomy. To help manage her chronic pain, she had a spinal cord stimulator implanted in or around July 2013. Patient C had shrapnel in her left lung from a prior gunshot wound. She had a history of bipolar disorder, depression, leukocytosis, phantom limb disorder, and Type II diabetes. To manage her pain, Patient C was taking a combination of extended and immediate release morphine sulfate.[13] On this visit date, Patient C reported that her pain control had improved. Respondent planned to continue Patient C's opiate therapy and refilled Patient C's morphine sulfate prescriptions.

64. According to CURES, on or about June 17, 2016 and August 17, 2016, Patient C filled prescriptions written by Respondent, each for 90 tablets of 200 mg morphine sulfate. On or about July 11, 2016 and August 10, 2016, Patient C filled prescriptions written by Respondent, each for 90 tablets of 30 mg morphine sulfate.

65. On or about August 23, 2016, Patient C returned to the clinic and saw Respondent. Respondent noted that he spoke to Patient C at length about her use of high dose narcotics. Respondent documented that he gave Patient C prescriptions for 90 tablets of 200 mg morphine sulfate to be taken every eight hours rather than as needed, and 90 tablets of 15 mg morphine sulfate to be taken three times daily, thereby reducing Patient C's daily opiate intake.

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[13] Morphine is an opiate and a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b).

66. On or about August 26, 2016, Patient C called Respondent's office. She wanted to discuss going off her medications. On or about August 29, 2016, Respondent noted that he would taper Patient C's medications when he provided her with her next prescription refill. When this message was relayed to Patient C, she stated that she called the wrong office and had intended to speak with her psychiatrist.

67. On or about September 9, 2016, Patient C filled a prescription written by Respondent for 90 tablets of 30 mg morphine sulfate. On or about September 16, 2016, Patient C filled a prescription written by Respondent for 90 tablets of 200 mg morphine sulfate. On or about September 24, 2016, Patient C filled a prescription written by Respondent for 90 tablets of 15 mg morphine sulfate.

68. On or about October 7, 2016, Patient C called Respondent's office to request refills for her morphine sulfate prescriptions. Patient C was told she needed to make an appointment with Respondent.

69. On or about October 18, 2016, Patient C returned to the clinic and saw Respondent. She complained of phantom limb pain and said that the pain was somewhat controlled with the medications. Respondent refilled Patient C's medications.

70. On or about the same day, Patient C submitted to a urine drug screen test at Respondent's office. The test was positive for benzodiazepines, marijuana metabolites, and opiates. According to CURES, Patient C was receiving prescriptions for carisoprodol, lorazepam, clonazepam,[14] and zolpidem tartrate from another treatment provider, presumably her psychiatrist. None of these medications that were prescribed by Patient C's psychiatrist were ever documented in Patient C's medical records as current medications.

71. On or about October 18, 2016, Patient C filled prescriptions written by Respondent for 90 tablets of 30 mg morphine sulfate and 90 tablets of 200 mg morphine sulfate.

72. On or about November 17, 2016, Patient C filled prescriptions written by Respondent for 60 tablets of 30 mg morphine sulfate and 90 tablets of 200 mg morphine sulfate.

[14] Clonazepam is a benzodiazepine and a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d).

73. On or about December 20, 2016, Patient C returned to the clinic and saw Respondent. She continued to complain of chronic pain, and said that the implanted neurostimulator gave little benefit. Respondent refilled Patient C's morphine sulfate prescriptions.

74. From on or about December 20, 2016 through March 24, 2017, Respondent continued to issue monthly prescriptions to Patient C for 90 tablets of 30 mg morphine sulfate and 90 tablets of 200 mg morphine sulfate.

75. On or about January 20, 2017, Patient C returned to the clinic and saw Respondent. Respondent gave Patient C referrals for a pain management specialist and a neurosurgeon.

76. On or about April 20, 2017, Patient C returned to the clinic and saw Respondent. Patient C told Respondent that she did not go see the pain management specialist because she "was doing just fine with what [she was] taking." Respondent refilled Patient C's medications.

77. From on or about April 21, 2017 to June 2, 2018, Respondent continued to issue monthly prescriptions to Patient C for 90 tablets of 30 mg morphine sulfate and 90 tablets of 200 mg morphine sulfate.

78. On or about June 13, 2017, Patient C went to a pain management specialist. Patient C was told to return to her primary care provider for a referral to an addictionologist, and that she could not be taken on as a patient because her MED[15] level was higher than the practice ~~sets~~ prescribed. Patient C was also counseled on the need to taper her medications.

79. On or about June 20, 2017, Respondent gave Patient C a referral to an opioid addiction specialist.

80. From on or about July 1, 2017 to August 4, 2017, Respondent continued to issue monthly prescriptions to Patient C for 90 tablets of 30 mg morphine sulfate and 90 tablets of 200 mg morphine sulfate.

81. From on or about August 28, 2017 to September 10, 2017, Patient C was hospitalized for pneumonia. On or about September 11, 2017, Respondent was notified that Patient C had a mass in her lung, and that it would be biopsied.

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[15] MED, or Morphine Equivalency Dose calculates the amount of morphine in various opioid medications.

82. On or about September 12, 2017, Patient C returned to the clinic and saw Respondent. Respondent gave Patient C a referral for more frequent home visits and refilled Patient C's medications.

83. From on or about September 12, 2017 to November 21, 2017, Respondent continued to issue monthly prescriptions to Patient C for 90 tablets of 30 mg morphine sulfate and 90 tablets of 200 mg morphine sulfate.

84. On or about September 20, 2017, Patient C returned to the clinic and saw Respondent. Patient C complained of chronic fatigue and requested referrals for a cardiologist and pulmonologist.

85. On or about November 9, 2017, Patient C returned to the clinic and saw Respondent. Respondent noted that Patient C was being followed by a cardiologist for broken heart syndrome, and that her pain was unchanged.

86. On or about November 29, 2017, Patient C went to the emergency room. Patient C was combative and disoriented. She complained of chronic abdominal pain, nausea, and vomiting. Patient C's treatment providers noted that her symptoms may be opioid-related and that they needed to rule out alcohol use or trauma.

87. On or about December 1, 2017, Patient C returned to the emergency room. She complained of increasing confusion, uncontrollable body movements, and abdominal pain. Treatment providers assessed her with acute dystonic reaction and leukocytosis. Patient C reported that she recently stopped seeing her psychiatrist and that she ran out of some of her psychiatric medications. After a neurology consultation, it was determined that Patient C's symptoms were likely related to her being unable to get her psychiatric medications. After being put back on her medications, she appeared to get better. Her treatment providers also noted that Patient C had a history of a self-inflicted gunshot wound and partial lobectomy, and that she had a possible new mass in her lung.

88. On or about December 12, 2017, Patient C returned to the clinic and saw Respondent. Patient C reported that she had abruptly stopped taking all of her psychiatric medications after her

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psychiatrist died, but that she had since been stabilized. Respondent refilled her medications and ordered a psychiatric referral.

89. On or about December 12, 2017 and December 19, 2017, Patient C filled prescriptions written by Respondent for 90 tablets of 30 mg morphine sulfate and 90 tablets of 200 mg morphine sulfate.

90. On or about December 21, 2017, Patient C returned to the clinic and saw Respondent. Patient C reported that she could not see a psychiatrist until the following month. In addition to her narcotic refills, Respondent refilled Patient C's prescriptions for sertraline,[16] benztropine-Cogentin,[17] and risperidone.[18]

91. On or about January 2, 2018, Patient C called Respondent's office and said she was going to run out of her morphine sulfate and diazepam[19] medications. She was advised that she had to make an appointment with Respondent in order to get her refills.

92. On or about January 9, 2018, Patient C returned to the clinic and saw K.G., a psychologist. Respondent had ordered an urgent behavioral health referral for Patient C. Patient C became agitated when K.G. explained that she was not a psychiatrist and could not prescribe medications. Patient C's psychiatrist had been prescribing hydroxyzine, sertraline, Ambien, Valium, and Soma. When her psychiatrist died, Patient C stopped taking her psychiatric medications, had a seizure, and was hospitalized. K.G. referred Patient C to a specialty mental health provider because of Patient C's complex medical history and numerous medications.

93. On or about January 10, 2018, Patient C returned to the clinic and saw Respondent. Patient C was attempting to taper down her narcotic medications. Respondent gave Patient C prescriptions for morphine sulfate and diazepam. He also reduced Patient C's 200 mg morphine tablets to 100 mg.

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[16] Sertraline, brand name Zoloft, is an anti-depressant.

[17] Cogentin, brand name for benztropine, is a medication used to treat involuntary movements caused by certain anti-psychotic medications.

[18] Risperidone is an anti-psychotic medication.

[19] Diazepam, brand name Valium, is a benzodiazepine and a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d).

94. On or about January 10, 2018, Patient C filled a prescription written by Respondent for 60 tablets of 5 mg diazepam. On or about January 12, 2018, Patient C filled prescriptions written by Respondent for 90 tablets of 30 mg morphine sulfate and 90 tablets of 100 mg morphine sulfate.

95. On or about January 12, 2018, Patient C requested an Ambien refill from Respondent through a pharmacist. Respondent's office told Patient C that her controlled medications would only be managed by one provider, and that if she wanted Respondent to prescribe Ambien, she had to come in for an appointment. A controlled medication agreement was mailed to Patient C to sign.

96. On or about February 6, 2018, Patient C returned to the clinic and saw Respondent. Respondent refilled Patient C's prescriptions for diazepam and morphine sulfate.

97. On or about February 9, 2018, Patient C filled prescriptions for 90 tablets of 100 mg morphine sulfate and 60 tablets of 5 mg diazepam. On or about February 12, 2018, Patient C filled a prescription written by Respondent for 90 tablets of 30 mg morphine sulfate. On or about March 12, 2018, Patient C filled another prescription written by Respondent for 60 tablets of 5 mg diazepam.

98. On or about March 13, 2018, Patient C returned to the clinic and saw Respondent. Patient C reported that she was still trying to taper her medication use. Respondent's plan was to reduce Patient C's extended release morphine to 60 mg dosing.

99. On or about March 14, 2018, Patient C filled a prescription written by Respondent for 90 tablets of 30 mg morphine sulfate.

100. On or about March 23, 2018, Patient C returned to the clinic and saw Respondent. Patient C reported that she was unable to obtain a prescription for the reduced dose of morphine sulfate because of insurance issues. Respondent discontinued the 100 mg morphine sulfate tablets and prescribed 180 tablets of 60 mg morphine sulfate (one or two tablets to be taken every eight hours) and 90 tablets of 30 mg morphine sulfate (one tablet to be taken every eight hours).

101. On or about March 30, 2018 and April 13, 2018, Patient C filled prescriptions written by Respondent for 180 tablets of 60 mg morphine sulfate and 90 tablets of 30 mg morphine

sulfate. On or about April 27, 2018, Patient C filled a prescription written by Respondent for 180 tablets of 60 mg morphine sulfate.

102. On or about May 14, 2018, Patient C returned to the clinic and saw Respondent. Patient C was requesting refills for morphine sulfate, gabapentin, and other medications. Respondent refilled Patient C's medications.

103. On or about May 14, 2018, Patient C filled a prescription written by Respondent for 90 tablets of 30 mg morphine sulfate.

104. On or about May 26, 2018, Patient C went to the emergency room. Patient C had been unable to take her medications for the previous three days because of nausea and acute worsening of abdominal pain. Patient C was counseled on reducing her chronic medications, and that some of her symptoms seemed to be related to opioid withdrawal.

105. On or about May 30, 2018, Patient C returned to the clinic and saw Respondent. Respondent documented that Patient C had gone to the emergency room for migraine headaches. Respondent refilled Patient C's medications and gave her a new prescription for temazepam.[20]

106. On or about May 30, 2018, Patient C filled a prescription written by Respondent for 180 tablets of 60 mg morphine sulfate. On or about June 13, 2018, Patient C filled prescriptions written by Respondent for 60 tablets of 5 mg diazepam and 90 tablets of 30 mg morphine sulfate. On or about June 26, 2018, Patient C filled a prescription written by Respondent for 180 tablets of 60 mg morphine sulfate.

107. On or about July 13, 2018, Patient C returned to the clinic and saw Respondent. Patient C wanted medication to help her sleep. Respondent refilled her medications and planned to wean her off of narcotics.

108. On or about July 13, 2018, Patient C filled prescriptions written by Respondent for 30 tablets of 30 mg temazepam and 90 tablets of 30 mg morphine sulfate.

109. On or about July 17, 2018, Patient C called Respondent's office and requested a pain management referral, which was given to her.

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[20] Temazepam is a benzodiazepine and a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d).

110. On or about July 21, 2018, Patient C filled a prescription written by Respondent for 180 tablets of 60 mg morphine sulfate.

111. On or about August 8, 2018, Patient C returned to the clinic and saw Respondent. Patient C reported that her chronic pain was unchanged, and that she wanted refills for morphine sulfate, diazepam, and temazepam. Respondent noted that Patient C had appointments to see a pain management specialist and a psychiatrist. Respondent refilled Patient C's medications.

112. On or about August 8, 2018, Patient C filled a prescription written by Respondent for 60 tablets of 5 mg diazepam. On or about August 9, 2018, Patient C filled a prescription written by Respondent for 30 tablets of 30 mg temazepam. On or about August 15, 2018 and August 20, 2018, Patient C filled prescriptions written by Respondent for 120 tablets of 15 mg morphine sulfate and 180 tablets of 60 mg morphine sulfate.

113. On or about September 12, 2018, Patient C returned to the clinic and saw Respondent. Respondent noted that Patient C had seen a pain management specialist twice, but that they were not managing her medications. On or about the same day, Respondent's office sent Patient C a letter which stated that the practice would no longer prescribe controlled medications to patients.

114. On or about September 28, 2018, Patient C went to the emergency room. She complained of phantom pain and reported that her primary care practitioner was no longer prescribing her pain medications. Patient C had run out of her morphine sulfate two days prior and had severe pains, trouble sleeping, and diarrhea.

115. On or about October 9, 2018, Patient C returned to the clinic and saw Respondent for a pre-operative evaluation. She was planning on having the neurostimulator removed on November 1, 2018.

116. On or about February 8, 2019, Patient C was hospitalized with an altered mental status, acute hypoxemia, and hypercapnic respiratory failure. She was given naloxone and intubated. Patient C was ultimately stabilized. Her hospital treatment providers recommended that Patient C reduce her opioid use by 30 percent and that she increase her gabapentin dose.

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They also cautioned her against the concurrent use of benzodiazepines and opiates, which could cause respiratory distress.

117. Respondent committed repeated acts of negligence in his care and treatment of Patient C which includes, but is not limited to, the following:

a. Respondent failed to properly monitor Patient C's chronic opioid therapy which would include periodic urine drug screens and/or a prescription for naloxone; and

b. Respondent concurrently prescribed benzodiazepines and opioids to Patient C, putting her at increased risk for accidental death from overdose, and Respondent failed to try to taper Patient C's medications as quickly as possible.

Patient D

118. Patient D had been an established patient at San Diego Family Care since at least 2010. On or about June 29, 2016, Patient D, then a 43-year-old male, returned to the clinic and saw Respondent for the first time. Patient D's pertinent medical history included diabetes, peripheral neuropathy, obesity, and depression. In or around May 2015, Patient D had his right leg amputated below the knee. Patient D's medication regimen included the following: trazodone,[21] Cymbalta,[22] and buspirone.[23] For pain, he was taking 100 to 200 mg of morphine sulfate every eight hours, and 60 to 120 mg of oxycodone every four hours as needed. Respondent noted that Patient D was on high dose narcotics and that an aggressive taper was needed. He gave Patient D prescriptions for morphine sulfate and oxycodone with directions that Patient D reduce his oxycodone dose to 90 mg a day.

119. On or about July 6, 2016, Patient D filled prescriptions written by Respondent for 90 tablets of 100 mg morphine sulfate (one or two tablets to be taken every eight hours) and 180 tablets of 30 mg oxycodone (two tablets to be taken every six hours). With the number of tablets prescribed, Patient D could take up to 300 mg of morphine sulfate and 180 mg of oxycodone per day.

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[21] Trazodone is an anti-depressant and sedative.
[22] Cymbalta, brand name for duloxetine, is an anti-depressant and nerve pain medication.
[23] Buspirone is an anxiolytic used to treat anxiety.

120. On or about July 20, 2016, Patient D called Respondent's office and requested early refills for his medications. Patient D also requested that his prescriptions be mailed to him, which was denied.

121. On or about August 16, 2016, Patient D called Respondent's office asking about the status of a mailed prescription. Patient D was told that the office did not mail secure prescriptions. Patient D also stated that Norco[24] was missing from his prescriptions and that 90 tablets of morphine sulfate were not enough. Patient D requested 150 tablets of morphine, which was denied.

122. On or about August 19, 2016, Respondent asked office staff about the status of a pain management referral for Patient D. He also requested a copy of Patient D's CURES report.

123. On or about August 23, 2016, Patient D called Respondent's office, again requesting Norco. Patient D was told that Respondent was only prescribing him morphine sulfate and oxycodone. Patient D reiterated that 90 tablets of morphine sulfate was not enough.

124. On or about September 9, 2016, Patient D filled prescriptions written by Respondent for 90 tablets of 100 mg morphine sulfate (one or two tablets to be taken every eight hours) and 240 tablets of 30 mg oxycodone (two tablets to be taken four times per day). With the number of tablets prescribed, Patient D could take up to 300 mg of morphine and 240 mg of oxycodone per day. Patient D refilled these prescriptions on or about October 18, 2016.

125. On or about November 8, 2016, Patient D returned to the office and saw Respondent. Patient D told Respondent he was taking approximately 6 tablets of oxycodone per day for breakthrough pain. Respondent refilled Patient D's medications, ordered hip and spine imaging,[11] and made a referral to a pain medicine specialist for a possible implant.

126. On or about November 22, 2016, Patient D filled prescriptions written by Respondent for 90 tablets of 100 mg morphine sulfate, one or two tablets to be taken every eight hours, and 90 tablets of 30 mg oxycodone, one tablet to be taken three times per day as needed. With the

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[24] Norco is the brand name for hydrocodone and acetaminophen. Hydrocodone is an opioid and a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b).

number of tablets prescribed, Patient D could take up to 300 mg of morphine and 90 mg of oxycodone per day.

127. On or about December 8, 2016, Patient D returned to the office and saw Respondent. Despite the instructions to taper oxycodone, Patient D reported taking approximately six oxycodone tablets per day. Respondent documented that he spoke to Patient D at length, telling him he needed to reduce his narcotic use and find alternative pain control methods. Once again, Respondent refilled Patient D's medications, ordered hip and spine imaging, and made a referral to a pain medicine specialist for a possible implant.

128. On or about December 8 and 9, 2016, Patient D called the office and requested to speak to the medical director to complain about Respondent.

129. On or about December 13, 2016, Patient D called and requested early refills of his medications, which he claimed Respondent approved. This request was denied.

130. On or about December 21, 2016, Patient D called again and requested a refill for his morphine sulfate prescription, saying he was going to run out of the medication the following day. Respondent gave Patient D refills for his medications.

131. On or about December 30, 2016, Patient D filled prescriptions written by Respondent for 90 tablets of 100 mg morphine sulfate and 120 tablets of 30 mg oxycodone, one tablet to be taken four times a day as needed. With the number of tablets prescribed, Patient D could take up to 300 mg of morphine and 120 mg of oxycodone per day.

132. On or about January 23, 2017, Patient D went to a pain management specialist. According to the medical records documenting this visit, Patient D told the specialist that he only went to the appointment at Respondent's insistence and that he had no intention of getting a spine implant. Patient D stated that he wanted to continue taking narcotics, and that he only went to the pain management appointment so that Respondent would continue to prescribe narcotics to him. The pain management specialist's office informed Respondent's office of Patient D's statements on or about the same day.

133. On or about January 23, 2017, Patient D called Respondent's office and requested morphine sulfate and Norco refills. Again, Respondent's office told Patient D that Norco was no

longer an active prescription. Respondent did authorize refills for morphine sulfate and oxycodone.

134. On or about February 6, 2017, Patient D filled prescriptions written by Respondent for 90 tablets of 100 mg morphine sulfate and 120 tablets of 30 mg oxycodone.

135. On or about March 2, 2017, Patient D called Respondent's office and requested refills, once again including Norco. Patient D reported that he was about to run out of his medications.

136. On or about March 9, 2017, Patient D filled prescriptions written by Respondent for 90 tablets of 100 mg morphine sulfate and 120 tablets of 30 mg oxycodone.

137. On or about March 30, 2017, Patient D called Respondent's office and requested refills for Norco, morphine sulfate, and oxycodone.

138. On or about April 5, 2017, Patient D returned to the office and saw Respondent. Patient D complained of phantom limb pain. He also said that his poor fitting prosthesis was causing increased pain. Respondent documented that he gave Patient D prescriptions for the following: (1) 90 tablets of 100 mg morphine sulfate; (2) 90 tablets of 20 mg oxycodone, one tablet to be taken three times per day as needed; and (3) 90 tablets of 15 mg oxycodone, one tablet to be taken three times a day as needed. At this visit, Patient D submitted to a urine drug screen, which was positive for morphine and oxycodone. Respondent noted that they were waiting for a pain medicine consultation and the plan was to wean narcotics as able.

139. According to CURES, on or about April 13, 2017, Patient D filled prescriptions written by Respondent for 90 tablets of 100 mg morphine sulfate and 90 tablets of 20 mg oxycodone. With the number of tablets prescribed, Patient D could take up to 300 mg of morphine and 60 mg of oxycodone per day.

140. From on or about May 16, 2017 through July 14, 2017, Respondent continued to issue monthly prescriptions to Patient D for 90 tablets of 100 mg morphine sulfate and 90 tablets of 20 mg oxycodone.

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141. On or about August 9, 2017, Patient D returned to the office and saw Respondent. Patient D agreed to sign a controlled substance agreement. Respondent gave Patient D prescriptions for 90 tablets of 100 mg morphine sulfate and 90 tablets of 15 mg oxycodone.

142. On or about August 15, 2017, Patient D filled a prescription written by Respondent for 70 tablets of 100 mg morphine sulfate. He filled another prescription written by Respondent for 90 tablets of 20 mg oxycodone, not 15 mg as documented in Patient D's medical records.

143. On or about August 29, 2017, Patient D called Respondent's office and requested early medication refills, which was denied. Refills were given on or about September 7, 2017.

144. On or about September 7, 2017 and September 14, 2017, Patient D filled prescriptions written by Respondent for 90 tablets of 100 mg morphine sulfate and 90 tablets of 20 mg oxycodone.

145. On or about September 29, 2017, Patient D called Respondent's office and requested early refills, stating that he was about to run out of his medications. Patient D claimed that Respondent did not tell him about the plan to taper his medications.

146. On or about October 6, 2017, Patient D returned to the office and saw Respondent. Respondent noted that Patient D was concerned about tapering his narcotic medications, and that "[Patient D] continues to be resistant to reduction in narcotics, alternative pain control intervention." Respondent documented that he lowered Patient D's narcotics, giving Patient D prescriptions for 90 tablets of 10 mg oxycodone, and 90 tablets of 100 mg morphine sulfate.

147. On or about October 6, 2017 and October 12, 2017, Patient D filled prescriptions written by Respondent for 90 tablets of 100 mg morphine sulfate and 90 tablets of 15 mg oxycodone, not 10 mg as documented in Patient D's medical records.

148. On or about October 30, 2017 and November 6, 2017, Patient D called Respondent's office and requested early refills. Patient D reported that he had taken extra oxycodone, in violation of his controlled medication agreement. Patient D was given refills on or about November 6, 2017.

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149. On or about November 6, 2017 and December 6, 2017, Patient D filled prescriptions written by Respondent for 90 tablets of 100 mg morphine sulfate and 90 tablets of 15 mg oxycodone.

150. On or about January 4, 2018, Patient D returned to the office and saw Respondent. Respondent noted Patient D's "personal history of noncompliance with medical treatment presenting hazards to health." He gave Patient D prescriptions for morphine sulfate and lowered the 15 mg oxycodone prescription from 90 to 60 tablets.

151. On or about January 4, 2018, Patient D filled prescriptions written by Respondent for 90 tablets of 100 mg morphine sulfate and 60 tablets of 15 mg oxycodone.

152. On or about January 26, 2018, Patient D called Respondent's office and requested early refills. Office staff noted that Patient D was getting increasingly upset.

153. On or about February 2, 2018, Patient D filled prescriptions written by Respondent for 90 tablets of 100 mg morphine sulfate and 60 tablets of 15 mg oxycodone.

154. On or about March 6, 2018, Patient D returned to the office and saw Respondent. Respondent refilled Patient D's medications and ordered a physical therapy referral to address Patient D's increasing weakness.

155. On or about March 6, 2018, Patient D filled prescriptions written by Respondent for 90 tablets of 100 mg morphine sulfate and 60 tablets of 15 mg oxycodone.

156. On or about April 4, 2018, Patient D returned to the office and saw Respondent. Patient D submitted to a urine drug screen, which was positive for opiates, morphine, morphine metabolites, oxycodone, and oxycodone metabolites.

157. On or about April 4, 2018, Patient D filled prescriptions written by Respondent for 90 tablets of 100 mg morphine sulfate and 90 tablets of 10 mg oxycodone.

158. On or about May 4, 2018, Patient D returned to the office and saw Respondent. Respondent documented that he gave Patient D a refill for morphine and increased the oxycodone to 20 mg tablets, quantity 90. Respondent did not document why Patient D's oxycodone dose was increased.

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159. On or about May 4, 2018, Patient D filled prescriptions written by Respondent for 90 tablets of 200 mg morphine sulfate and 90 tablets of 10 mg, not 20 mg, oxycodone.

160. On or about May 31, 2018, Patient D called Respondent's office and stated that he had been in the hospital for approximately 13 days and needed refills for his medications. Patient D stated that he had multiple surgeries.

161. According to his CURES report, from on or about June 18, 2018 through July 13, 2018, Patient D filled prescriptions for morphine sulfate and oxycodone from two other treatment providers. Within that period of time, Patient D also filled two prescriptions written by Respondent: (1) 45 tablets of 100 mg morphine sulfate; and (2) 45 tablets of 10 mg oxycodone.

162. On or about July 18, 2018, Patient D called Respondent's office. Patient D was told that Respondent would no longer be prescribing narcotic medications after August 9, 2018.

163. On or about July 25, 2018, Patient D filled prescriptions written by Respondent for 90 tablets of 100 mg morphine sulfate and 90 tablets of 20 mg oxycodone.

164. On or about August 20, 2018, Patient D returned to the office and saw Respondent. Patient D's hospitalization was for multiple medical problems including abscesses and urinary obstruction, and a blood clot in the lungs. Patient D was requesting home care and a new prosthesis. Patient D was given referrals to home health care, urology, and prosthetics, and placed on blood thinner medications.

165. On or about September 13, 2018, Patient D filled a prescription written by Respondent for 90 tablets of 20 mg oxycodone.

166. On or about September 18, 2018, Patient D saw another pain specialist. This pain specialist ordered neurology, cardiology, and psychiatric consultations.

167. On or about September 27, 2018, Patient D called Respondent's office. He reported that he had gone to his pain management appointment, but that he needed a neurology referral before the pain management doctor would provide narcotic prescriptions. Patient D was requesting that Respondent refill his medications. Respondent's office gave him the neurology referral, but refused to refill Patient D's medications, citing Respondent's controlled medicine policy.

168. On or about October 2, 2018, Patient D returned to the office and saw Respondent. Patient D was requesting refills for morphine sulfate and oxycodone. Respondent documented that the controlled substance policy was reviewed and gave Patient D a prescription for tramadol.[25]

169. Respondent committed negligence in his care and treatment of Patient D which includes, but is not limited to, the following:

a. Respondent failed to properly monitor Patient D's chronic opioid therapy which would include more frequent periodic urine drug screens and/or a prescription for naloxone.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate No. C 54416, issued to Respondent Jeffrey A. Cullen, M.D.;

2. Revoking, suspending or denying approval of Respondent Jeffrey A. Cullen, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Respondent Jeffrey A. Cullen, M.D., to pay the Board the costs of the investigation and enforcement of this case, and if placed on probation, the costs of probation monitoring; and

4. Taking such other and further action as deemed necessary and proper.

DATED: FEB 15 2022

WILLIAM PRASIFKA
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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[25] Tramadol is a centrally acting opioid analgesic used to treat moderate to severe pain. It is a Schedule IV controlled substance pursuant to the Controlled Substances Act.